Section II – General Operations / Organizational Structure

1. Governance
   - Interviews
   - Prioritized Recommendation Summary
   - Introduction

Governance > Interviewees

• Hospital Administrators	Harbor-UCLA Medical Center
	Olive View-UCLA Medical Center
• Dr. Thomas Garthwaite	Los Angeles County Health Department
• Fred Leaf	Los Angeles County Health Department
• John Wallace	Los Angeles County Health Department
• Lila Kapur and Others	Los Angeles County Attorneys

Governance > Prioritized Summary of Recommendations

Management Structure		
Urgent	2.1.01	Appoint a separate, independent, knowledgeable Board for KDMC.
Urgent	2.1.02	Work with the LA County DHS and legal department personnel to review the information provided in the report(s) that evaluate legal feasibility of alternative governance structures for county hospitals. If the LA county legal review shows it is feasible, consider development a separate Hospital Authority.
Urgent	2.1.03	Develop and implement new reporting criteria, including metrics by which the oversight body can compare KDMC performance
Urgent	2.2.04	Develop procedures by which a new oversight body will identify for reporting issues, a process for developing metrics to measure performance, and as well as reporting formats.
Urgent	2.2.05	Create a community advisory panel who will meet with the oversight body on a quarterly basis.
Urgent	2.2.06	Work with DHS and the Board of Supervisors to identify and document the process and procedures, topics, and content (taking into consideration confidentiality) of communications and interface between the Board of Supervisors and the oversight body.

Now (Dec) Urgent (Jan-Feb) Short term (2-6 months) Intermediate (4-9 months) Long term (>9 months)

Governance > Introduction

- The cornerstone of any successful organization is the existence of a governing body and process that ensures that management is effectively and efficiently managing the organizations operations. In the post Enron era, board oversight of management and the organization's operations has taken on a new level of significance, with an emphasis on board of director, management, and employee accountability, compliance with policy and procedure. The board of directors are expected to validate the accuracy of information provided to it by management and to aggressively take action to timely correct problems identified from their oversight efforts.
- In the hospital setting, corporate governance takes on an additional level of importance where the organization is one that provides health care services to patients, who enter the doors of an institution and entrust their well being based on a belief that the organization and its employees will use their best efforts to treat them and restore their health if possible. For those organizations that are public hospitals, the expectations should be of an equal or higher level as the organizations exist to serve its community members.
- The four critical factors for the successful oversight of an organization are:
  - Independence in decision making;
  - Accurate and timely reporting;
  - Validation of reported information; and
  - Empowerment to implement change.

Governance

Assessment

- It is with this perspective of corporate governance that NCI conducted its review of the current and historical corporate governance of KDMC. As a precursor to identifying a best practice for future corporate governance of KDMC, NCI reviewed the historical and current oversight structure, reporting mechanisms and content, Los Angeles County policy, procedures, legal, political, and operational factors that have and potentially could impact a future oversight process for the hospitals operations. The following discussion documents the information obtained during the first phase of our engagement.

Historical Governance

- NCI conducted interviews with the LA County DHS personnel, senior management of the other LA County hospitals, and LA County legal counsel.
- In addition, NCI reviewed the current reporting documents provided to DHS by the county hospitals. The focal point of our document review was to determine what information was provided to DHS, the level of detail, and determine if a differential existed between the county hospitals and if the reasons.

Governance

Hospital Reporting of Operations

- NCI requested from DHS copies of documents submitted by the individual county hospitals. Based on our review of the documents provided, NCI believes the scope, detail, and absence of comparative metrics make the current reporting documentation insufficient for effective corporate governance oversight. More detailed reporting of clinical outcomes, and the hospital business processes and procedures that impact the delivery of quality health care should be added. Metrics should be defined for each reporting topic that would be used by the oversight personnel to make a comparative evaluation of a hospital's reported performance to expected best practice performance levels

Governance Process/Meetings

- NCI conducted interviews with both DHS personnel and current hospital administrators. The reports prepared by management are delivered to DHS the day of the meetings. Based on our discussions, the current meeting process for the county hospitals with the hospital administrators are more focused on an opportunity for the medical staff's representatives to discuss program concerns with DHS representatives. Although an important component of the hospitals mission is to provide services to its community, the current focus of the meetings and the level of management interaction provides for inefficiencies, and undermines the effectiveness of the oversight process.

Governance

Oversight Responsibility

- The Los Angeles Board of Supervisors is the entity that is responsible for the oversight and governance of county hospitals. Much as a private non-profit or for-profit board of directors, the Los Angeles Board of Supervisors has the ultimate oversight responsibility for county hospital operations.
- The Board of Supervisors has delegated the responsibilities of a typical hospital board of directors to the LA County DHS. The DHS Medical Director, the DHS COO and their senior reports have assumed the responsibility delegated to them and are responsible for review of corporate governance documents submitted by each county hospital and for meeting with management to discuss hospital operations.

Governance

Historical Factors

- As part of our review, NCI asked DHS personnel, county legal department representatives, and hospital management to identify their perception of obstacles that have undermined the historical governance of MLKs operations. The obstacles identified as the most problematic included:
  - Civil service employment system:
  - Organized labor issues;
  - Drew Medical School issues;
  - Ability to attract management personnel;
  - Ability to provide incentives for employee performance;
  - Employee performance, skills, attitude; and
  - "Politics".
- Although all of these factors had a critical impact on KDMC corporate governance and day-to-day operations, the factor which appeared to be the most disruptive was politics.
- According to DHS, historically, KDMC management and employees have effectively used political intervention that has impacted not only corporate governance issues, but day-to-day operational decisions.

Governance

Corporate Governance Legal Considerations

- NCI held discussions with legal counsel from LA County to develop an understanding of obstacles or limitations in the definition of a new corporate governance process. During these discussions, it was identified that a comprehensive review of governance options is being completed with the assistance of the county legal department personnel. At the time the review was initiated, the business driver for the review was the financial condition of the LA County. However, the information documented in the report(s) will provide comprehensive information that is relevant to the current review of KDMC.

Governance

Deficiencies

- It is clear that the historical corporate governance process has been ineffective in ensuring quality health care and addressing the operational issues at KDMC. The current structure and process have been impacted by several critical facts that have undermined the efforts to monitor and effectively address KDMC operational and quality assurance shortfalls.
- From a corporate governance perspective, independence, thorough reporting, validation of reporting, empowerment, and a perspective by all parties including oversight, management, physicians, staff, the community and patients that anything less than excellence in clinical outcomes are lacking.
- There needs to be a corporate governance determined to overcome obstacles. The oversight body needs to be empowered to make changes. It needs to be independent of the historical political interference.

Governance

Recommendations

2.1.01 Appoint a separate, independent, knowledgeable Board for KDMC.

2.1.02 Work with the LA County DHS and legal department personnel to review the information provided in the report(s) that evaluate legal feasibility of alternative governance structures for county hospitals. If the LA county legal review shows it is feasible, consider development a separate Hospital Authority.

2.1.03 Develop and implement new reporting criteria, including metrics by which the oversight body can compare KDMC performance. The scope of reporting will include as an example:

- Information regarding clinical outcomes,
- Data metrics regarding performance errors such as prescription errors,
- Quality assurance,
- Physician credentialing,
- Physician disciplinary issues,
- Measurements of operational procedures that impact patient care such as length of wait time in the emergency room prior to being transferred to a inpatient bed,
- Information regarding any and all corrective action plans,
- Information the progress of implementing initiatives.

Governance

Recommendations

2.1.04 Develop procedures by which a new oversight body will identify for reporting issues, a process for developing metrics to measure performance, and as well as reporting formats.

2.1.05 Create a community advisory panel who will meet with the oversight body on a quarterly basis.

2.1.06 Work with DHS and the Board of Supervisors to identify and document the process and procedures, topics, and content (taking into consideration confidentiality) of communications and interface between the Board of Supervisors and the oversight body.

Section II – General Operations / Organizational Structure

2. Management/Structure
   - Interviews
   - Prioritized Summary of Recommendations
   - Organizational Structure
   - Communications

Management / Structure > Interviews

- Senior Management Team
- Department Directors
- Clinical Chairs
- DHS Communication Office

Management / Structure > Prioritized Summary of Recommendations

Management Structure		
Urgent	2.2.01	Emphasize proactive problem solving and decision making.
Urgent	2.2.02	Clearly identify roles and corresponding responsibility and authority.
Urgent	2.2.03	Enhance collaboration and cooperation among hospital departments and clinical services.
Urgent	2.2.04	Establish consistent expectations for work product and timely decision making.
Urgent	2.2.05	Evaluate systems for documentation, data collection, analyses, audit and support of decision-making process.
Urgent	2.2.06	Institute regular management team meetings that are intra-departmental and inter-departmental.
Urgent	2.2.07	Consolidate management positions and roles as appropriate, and re-align reporting relationships.
Communications		
Urgent	2.2.08	DHS to re-locate at a minimum one half-time position to support all communication efforts of the hospital.
Urgent	2.2.09	Establish standards for presentation to assure quality of presentation, clarity of message and content.
Urgent	2.2.10	Publish an employee/staff newsletter at a minimum once a month in a standardized format.
Urgent	2.2.11	Enhance communications with the press; meet with editorial boards to foster beneficial relationships.
Urgent	2.2.12	Implement a user guide for media services.
Urgent	2.2.13	Require department directors to meet regularly with staff members on all shifts to assure proper flow of information.
Urgent	2.2.14	Develop a comprehensive communication plan.
Urgent	2.2.15	Ensure a broad dissemination of information to staff in an effective format.

Now (Dec) Urgent (Jan-Feb) Short term (2-6 months) Intermediate (4-9 months) Long term (>9 months)

Management / Structure > Organizational Structure

Assessment

- Lack of a comprehensive strategic plan.
- Individuals do not have goals and objectives.
- Responsibilities of management staff are not consistent or predictable.
- Current management structure does not facilitate an efficient/effective decision-making process.
- Responsibility and authority for making decisions is not always clear.
- Often times, the management team functions in a crisis mode, resulting from a lack of planning, direction and delayed decision making.
- Critical situational analyses and decision making is not always evident.
- Managers are not required to be fiscally responsible for their departments.
- Managers have little or no input into the budget process resulting in a lack of accountability and ownership.
- Limited use of data analysis in decision making.

Deficiencies

- There is no comprehensive strategic planning.
- Lack of overall responsibility and accountability by management for the decision-making process and routine operations.
- There is a failure to develop systems to gather, analyze and apply basic industry-wide standards and data elements to the decision-making process and in setting strategic goals for KDMC.

Management / Structure > Organizational Structure

Recommendations

2.2.1 Emphasize proactive problem solving and decision making.

2.2.2 Clearly identify roles and corresponding responsibility and authority.

2.2.3 Enhance collaboration and cooperation among hospital departments and clinical services.

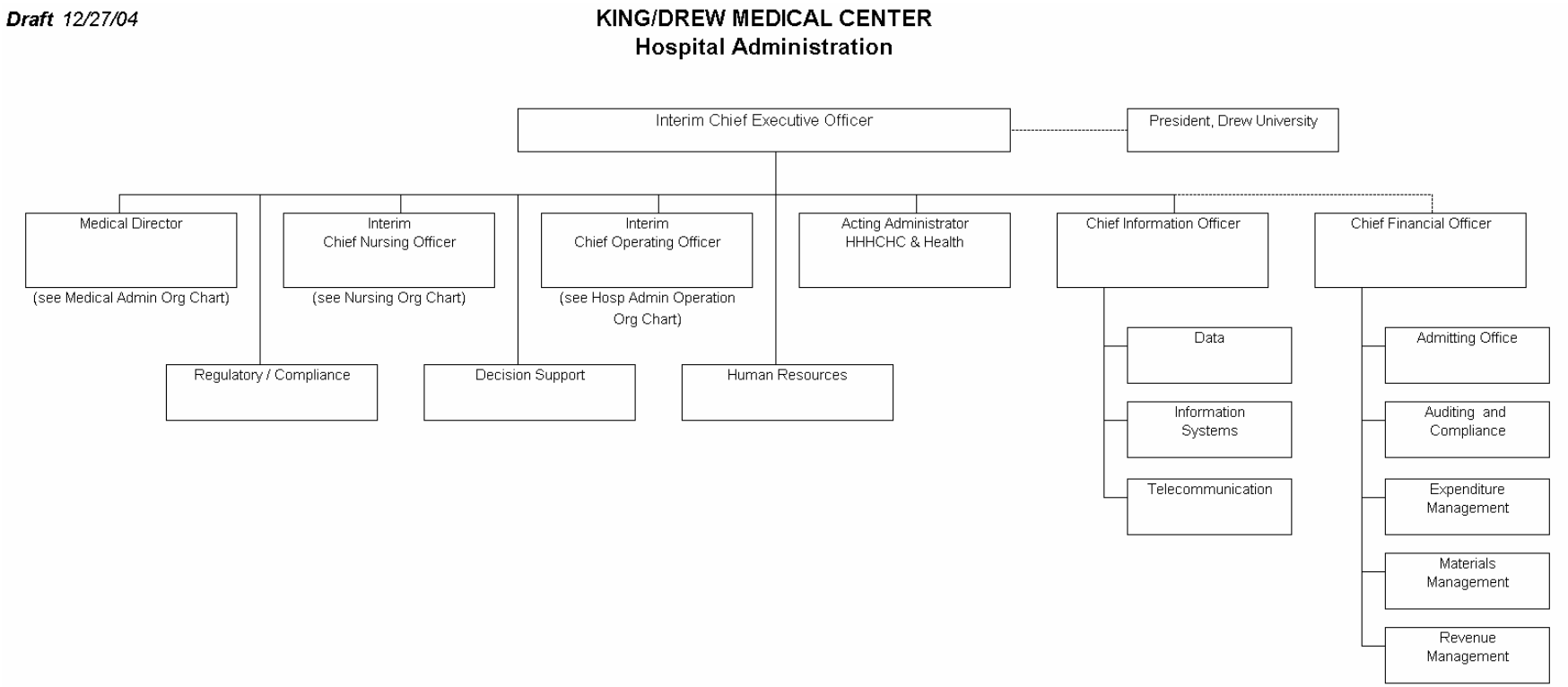
2.2.4 Establish consistent expectations for work product and timely decision making.

2.2.5 Evaluate systems for documentation, data collection, analyses, audit and support of decision-making process.

2.2.6 Institute regular management team meetings that are intra-departmental and inter-departmental.

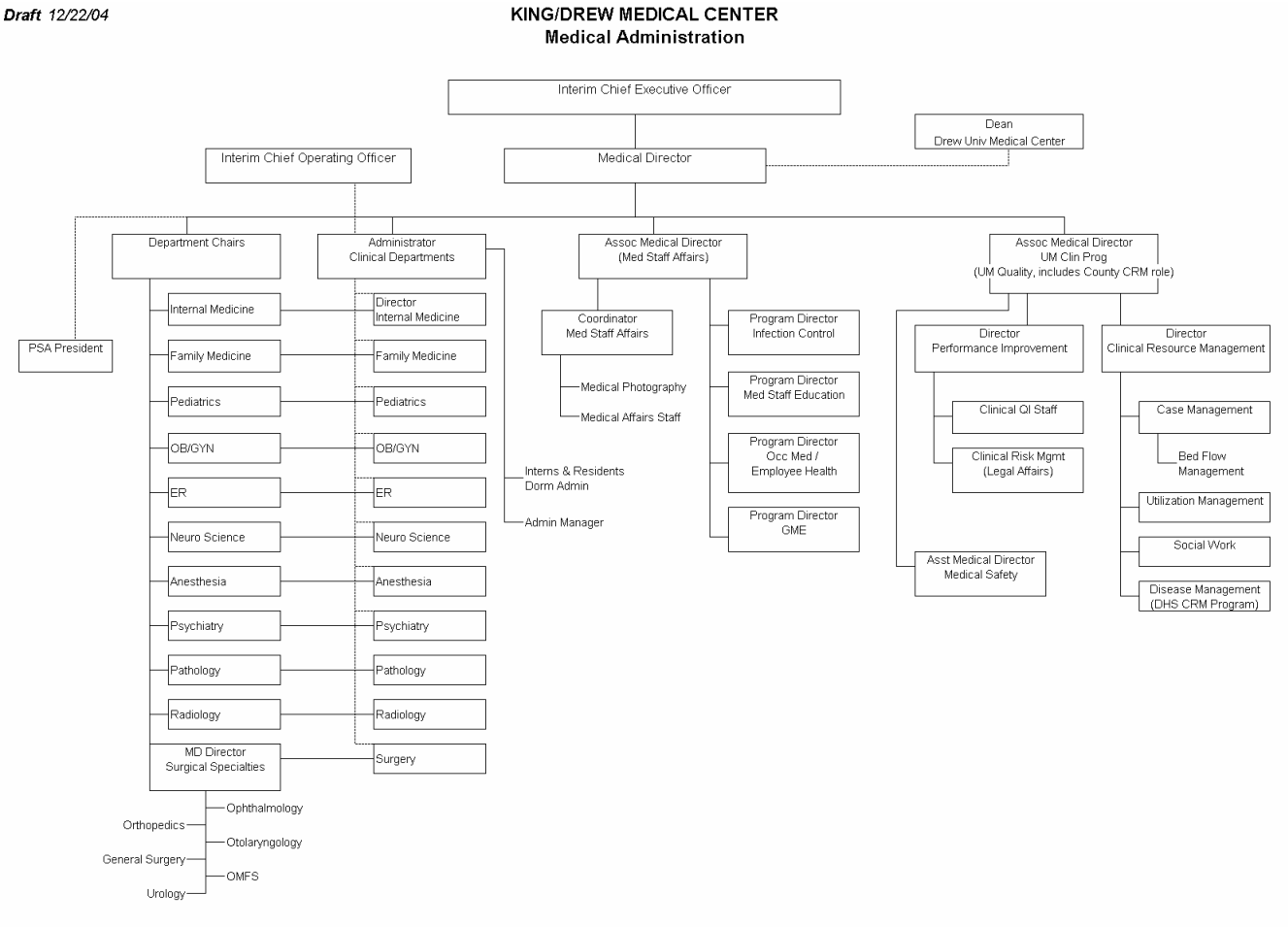
2.2.7 Consolidate management positions and roles as appropriate, and re-align reporting relationships to promote improved decision making and implementation along with ongoing oversight.

Proposed Organizational Chart: Hospital Administration



Management/Structure

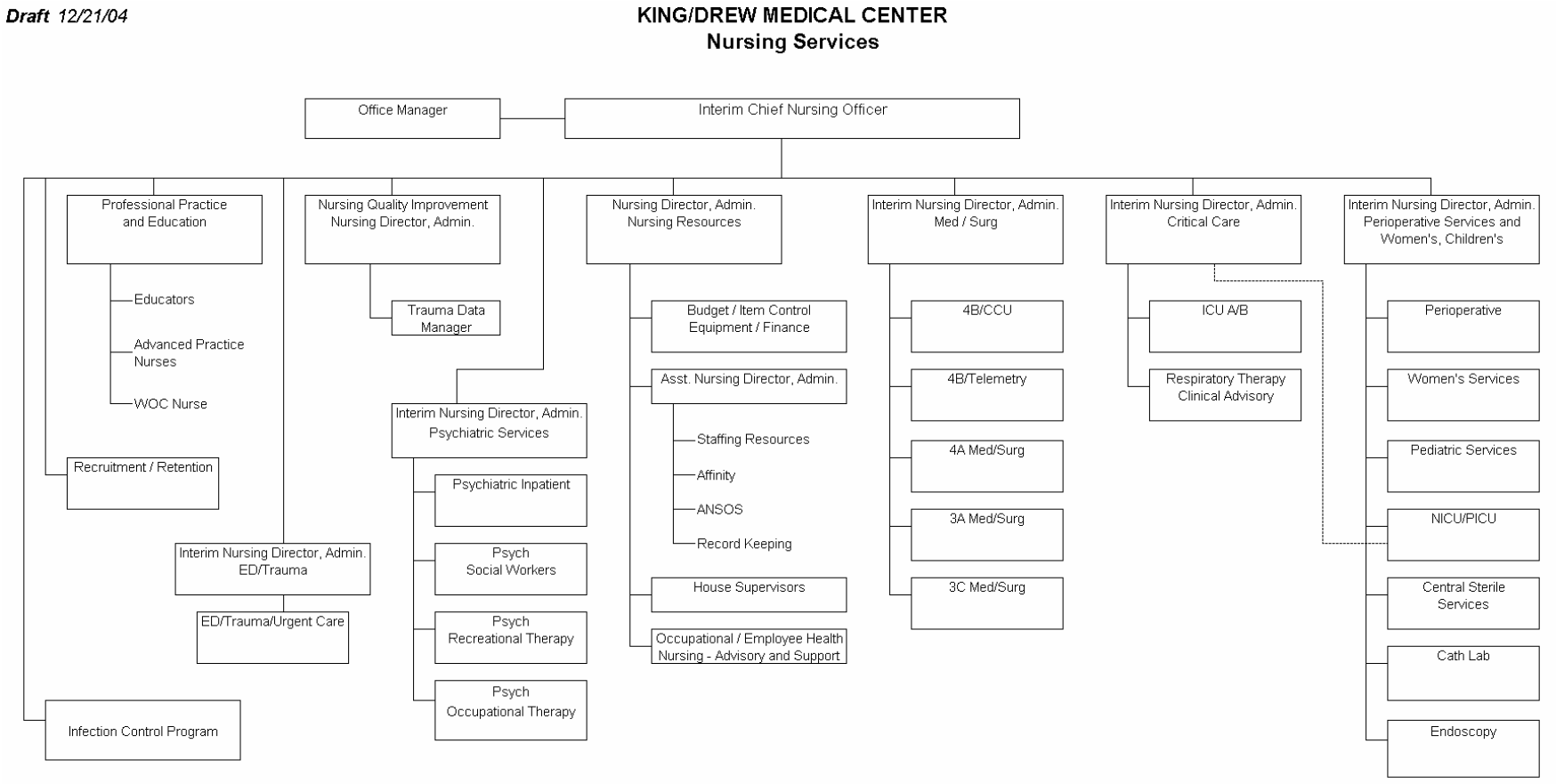
Proposed Organizational Chart: Medical Administration



NAVIGANT CONSULTING

Management/Structure

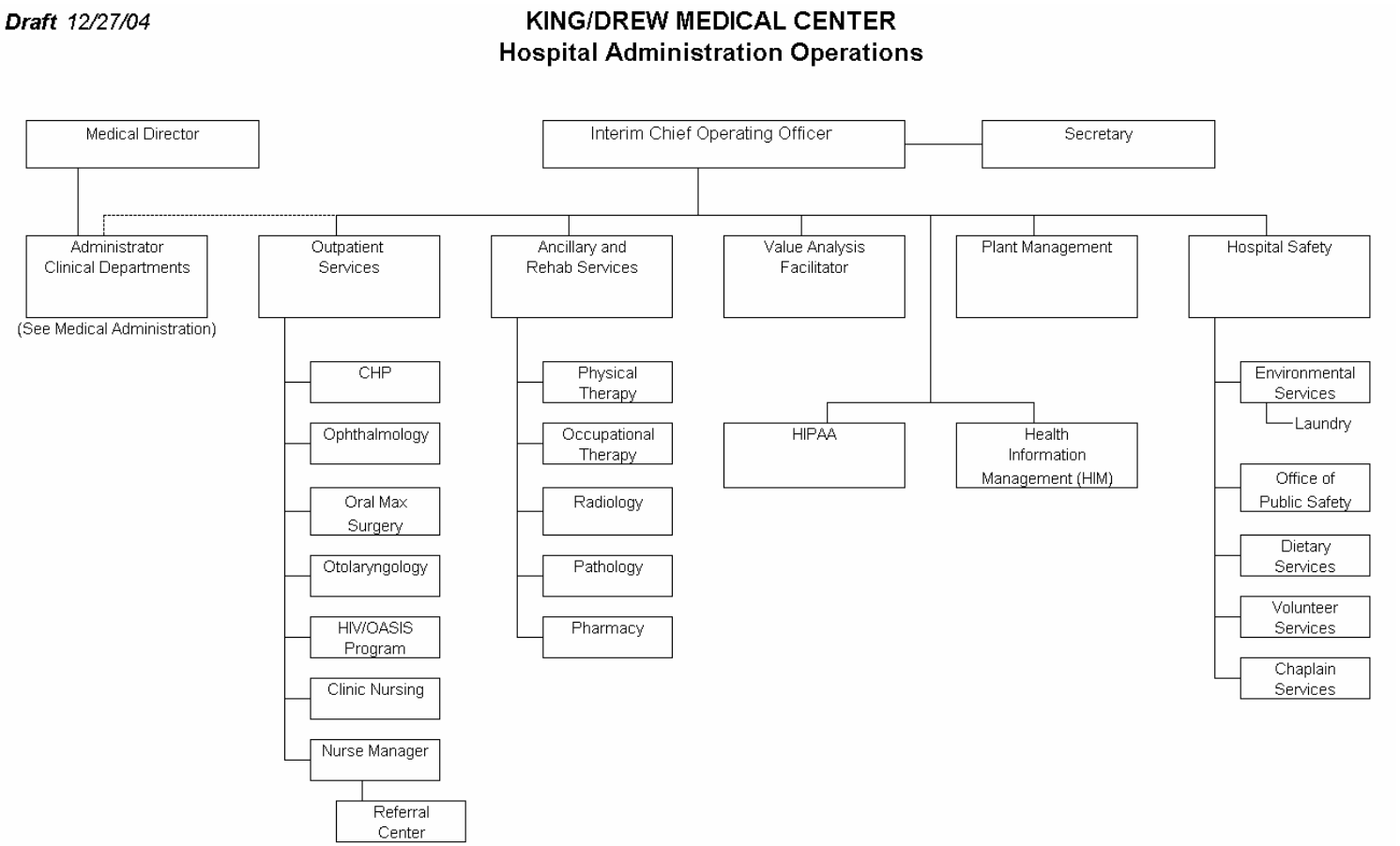
Proposed Organizational Chart: Nursing Service



NAVIGANT CONSULTING

Management/Structure

Proposed Organizational Chart: Operations



NAVIGANT CONSULTING

Management / Structure > Communications

Assessment

- Communication with the public when it does occur is decentralized throughout the organization with individual departments either distributing flyers, posting notices or contacting community groups on an ad-hoc basis.
- There are no standards that have been established and distributed to assure uniformity of presentation in regard to branding, content of message and means of appropriate distribution.
- No formal staff/employee newsletter currently exists that is distributed throughout the organization on a predictable schedule.
- Media relations is perceived by many to operate in a reactive mode to negative coverage as opposed to being proactive in creating positive story-lines and getting good news out to the public through the media.
- Media relations is currently centralized in the offices of DHS. Many have a limited understanding as to how best to access and use this resource.
- There is a failure to integrate the regulatory compliance process into an overall communications plan.
- The organization is reactionary rather than proactive with respect to communicating with regulatory agencies.
- Information on the organization's performance on regulatory surveys has been closely held by senior management and has not been widely communicated to middle management and staff who are integral to the resolution of the issues.

Management / Structure > Communications

Deficiencies

- Failure to be proactive in communicating with the media, the public and employees, and a lack of clarity in message and mode of delivery.
- Lack of resources to assure timely and consistent communication in support of organizational goals and needs, as in resolving regulatory issues and meeting the needs of those served.
- No comprehensive communication plan.

Management / Structure > Communications

Recommendations

2.2.8 DHS to re-locate at a minimum one half-time position to support all communication efforts for the hospital. While on-site this position should report to the CEO/COO for setting priorities.

2.2.9 Standards for presentation should be established to assure quality of presentation, clarity of message and content.

2.2.10 Publish an employee/staff newsletter at a minimum once a month in a standardized format. This instrument should be used to communicate with staff the changes that will be realized in the coming months.

2.2.11 Proactively manage media relations with the public as change occurs and positive results are documented. Enhance communications with the press, such as meeting with their editorial boards to foster beneficial relationships.

2.2.12 Implement a user guide for media services.

2.2.13 Require department directors to meet on a regular basis with their staff members on all shifts to assure proper flow of information.

2.2.14 Develop a comprehensive communication plan. Identify key stakeholders/audiences, define messages and the type of media to be used.

2.2.15 Ensure a broad dissemination of information to staff in an effective format.

Management / Structure

Responsibility

- KDMC Senior Management Team
- DHS Leadership
- DHS Communication Office

Section II – General Operations / Organizational Structure

3. Risk Management
   - Interviews
   - Prioritized Summary of Recommendations

Risk Management > Interviews

• E. Bradley	Risk Manager
• C. Black, MD	Advisor to Medical Director
• P. Price	Chief Nursing Officer
• L. Knight	Director, Quality Management
• L. Saarf	Director, Quality Improvement Program, DHS
• R. Peeks, MD	Medical Director

Risk Management > Prioritized Summary of Recommendations

Short term	2.3.01	Review and revise the risk management process.
Intermediate	2.3.02	Plan and present regular educational programs to clinical and administrative departments.
Intermediate	2.3.03	Review and revise the inicent reporting policies and procedures.
Urgent	2.3.04	Educate all health care providers on the complete hospital incident reporting procedures.
Urgent	2.3.05	Establish a procedure that ensures the Report of Incident Forms and other significant incidents are reviewed on an ongoing basis by appropriate departments and committees.
Urgent	2.3.06	Ensure and monitor that each service reviews and analyzes all reported incidents on an on going basis and reports trends and corrective actions.
Short term	2.3.07	Institute a program to improve relationships between patients and providersto learn techniques for increasing patient satisfaction.
Urgent	2.3.08	Ensure an effective, comprehensive informed consent process.
Urgent	2.3.09	Ensure all health care providers comply with federal, state and municipal rules and regulations.
Urgent	2.3.10	Review all confidentiality policies and procedures and ensure compliance.
Now	2.3.11	Ensure that all discussion of patient related information is conducted in appropriate locations.
Urgent	2.3.12	Review policies regarding patient related information and ensure compliance.
Urgent	2.3.13	Ensure meetings to discuss patients are conducted in appropriate locations and materials distributed should be collected and not left for members of the general public to find.
Urgent	2.3.14	Ensure all health care providers are familiar with patients' rights under state law and hospital policy and observe them at all times.
Urgent	2.3.15	Ensure that appropriate assistance is provided to patients including the use of an interpreter, to ensure that patients understand their rights.
Urgent	2.3.16	Ensure appropriate policies and procedures are followed for patients to review and or obtain a copy of their medical record.
Short term	2.3.17	Identify a process for patients, or appropriate family members, to be informed promptly about unexpected and/or negative outcomes.
Urgent	2.3.18	Ensure that policies and procedures ion the use of restraints are followed and documented.
Urgent	2.3.19	Ensure that policies and procedures are followed when a patient refuses treatment including his/her voluntary decision to be prematurely discharged.
Urgent	2.3.20	Develop key metrics for hospital performance and track on a monthly basis.
Urgent	2.3.21	Implement the UHC database and standardize performance measures to benchmark performance.

Now (Dec) Urgent (Jan-Feb) Short term (2-6 months) Intermediate (4-9 months) Long term (>9 months)

Risk Management

Assessment

- There is a staff of approximately seven FTEs, consisting of a director, four professionals, including a nurse and an attorney, and two clerical staff.
- The director and attorney report directly to the Chief Medical Officer.
- The scope of the Risk Management function primarily involves the management of medical liability cases.
- There is minimal emphasis on education and prevention. There is also minimal involvement in general liability management.
- The department interfaces with clinical departments, all services involved in quality reviews, medico-legal services, County Counsel and others.
- There is little automation of claims, although access to the University Hospital Consortium database is in process County-wide.
- The quality of the working relationships between Risk Management and Quality, Nursing, CRM and others is observed to be contentious.
- There is a formal incident reporting process but reports are inconsistently routed to risk management. In addition, while individual cases are reviewed, aggregate data is not developed or reviewed for trends or clusters.
- There is no database to capture claims or incident reports, and no integration of information with quality, safety, credentialing or privileging activities.
- The legal function consists primarily of interfacing with the malpractice administrator and orchestrating reviews to consider settlements.

Risk Management

Assessment

- The Risk Manager reports incidents by location/unit and include all occurrence types.

Incident By Location Data: Incidents by Occurrence Type
Number/Volume of Occurrences

	January, 2004	February, 2004	March, 2004	April, 2004	May, 2004	June, 2004	July, 2004	August, 2004	September, 2004	October, 2004
Decubitus	12	19	17	12	11	10	8	6	9	12
Medication Event	14	11	78	24	15	10	25	22	12	10
Patient Fall	8	10	7	14	4	10	11	3	4	10
Delay in Treatment	10	12	6	17	14	10	5	5	1	2
IV Infiltrate	1	1	0	5	1	4	4	3	1	0
Treated/Discharged/Returned	1	1	0	0	0	1	0	1	0	0
Total # of Incidents (All Occurrence Types)	243	227	335	277	257	218	246	302	178	176

*The % Total Incidents for each occurrence type is the number of instances for that occurrence type over the total # of incidents (all occurrence types) as reported on the Incident by Location report).

Source: KDMC Incident by Location Reports (January, 2004 through October, 2004)
Provided by Elcedo Bradley (KDMC Risk Manager)

- A recent enhancement installed by the organization's performance measurement system vendor (University Healthcare Consortium) provides attending physician-specific data on performance of core measure activities. This feature will provide peer review data for the credentialing and privileging process.

Risk Management

Deficiencies

- There is poor compliance with incident reporting of policies and procedures.
- There is little emphasis on education and risk prevention.
- There is little coordination among Risk Management and other departments involved in quality review, safety or credentialing.
- Steps taken after an event occur are not integrated into a comprehensive prioritized plan.
- There are multiple reactive plans.
- The approach is not multidisciplinary nor proactive.
- There is little automation to help organize data and recognize trends.
- There is almost no attention paid to issues of general liability.

Risk Management

Recommendations

2.3.1 Review and revise the risk management process.

- The process should include a mechanism and correct situations or problems which may give rise to events or incidents of potential liability for the hospital, its employees, physicians and other health care providers.

2.3.2 Plan and present regular educational programs to clinical and administrative departments which includes:

- orientation of new employees including medical staff, residents and nurses;
- continuing education in the form of in-service programs regarding medical-legal and risk management related subjects; and
- special seminars or conferences for target audiences in response to particular risk management problems.

2.3.3 Review and revise the incident reporting policies and procedures.

- Identify the steps which are taken after an event or incident occurs to minimize the adverse impact, financial or otherwise, of the event or incident on the patient, the hospital and its staff. Include involvement and input from a number of the medical and administrative staff throughout the hospital.

2.3.4 Educate all health care providers on the complete hospital incident reporting procedures.

Risk Management

2.3.5 Establish a procedure that ensures the Report of Incident forms and other significant incidents are reviewed on an ongoing basis by appropriate departments and committees. This review process allows for:

- Identification and documentation of trends within service(s) and those that cross over services that might affect policies or procedures.
- Recognition and identification of hospital-wide programs to correct identified problems
- Assessment of conformance to required standards of practice and care.

2.3.6 Ensure and monitor that each service reviews and analyzes all reported incidents on an ongoing basis and reports trends and corrective actions taken as part of the periodic QA/QI reports.

2.3.7 Institute a program to improve relationships between patients and providers to learn techniques for increasing patient satisfaction through improved communication are now widely recommended for malpractice claims prevention.

2.3.8 Insure an effective, consistent, comprehensive informed consent process, including revision of the standard form and policy to conform with regulatory requirements.

2.3.9 Ensure all health care providers comply with federal, state and municipal rules and regulations, in addition to the hospital's policies and procedures regarding the control of infectious disease. Including:

- Preventing and reporting communicable diseases
- Universal blood and body fluid precautions
- Needlestick precautions
- Proper medical waste disposal

2.3.10 Review all patient confidentiality policies and procedures and insure compliance.

2.3.11 Ensure that discussion of patient related information is conducted only in locations where confidentiality can be maintained. Measures are taken to ensure that providers should refrain from such discussions in elevators, hallways, dining areas and other public areas.

2.3.12 Ensure the storage and protection of patient information according to hospital policy. Measures to protect access to patient information via electronic systems should be implemented according to hospital policy, with access code and password security maintained.

2.3.13 Ensure meetings to discuss patients are conducted in appropriate locations and materials distributed should be collected and not left for members of the general public to find.

Risk Management

2.3.14 Ensure all health care providers are familiar with patients' rights under state law and hospital policy and observe them at all times.

2.3.15 Ensure that appropriate assistance is provided to patients including the use of an interpreter, to ensure that patients understand their rights.

2.3.16 Ensure appropriate policies and procedures are followed for patients to review and or obtain a copy of their medical records (after discharge if the record is a hospital record).

2.3.17 Identify a process for patients, or appropriate family members, to be informed about unexpected and/or negative outcomes promptly. This should include the nature and cause of the event, if known, as well as the manner in which the event will affect the patient's prognosis and treatment plan.

2.3.18 Ensure that policies and procedures on the use of restraints are followed and documented.

2.3.19 Ensure that policies and procedures are followed when a patient refuses treatment including his or her voluntary decision to be prematurely discharged.

2.3.20 Develop key metrics for hospital performance and track them on a monthly basis, and integrate provider specific data into credentialing ang privileging activities.

2.3.21 Implement the UHC database and standardize performance measures to benchmark performance.

Risk Management

Responsibility

- CEO
- Medical Director
- Risk Manager

Section II – General Operations/Organizational Structure

4. Regulatory
   - Interviews
   - Prioritized Summary of Recommendations
   - Compliance Profile
   - Structure, Leadership and Oversight
   - Process

Regulatory > Interviews

- L. Knight — Administrative Director, Quality Management/Regulatory Programs
- R. Peeks, MD — Medical Director
- P. Valenzuela — Lead Administrator, Ancillary & Rehab Services
- P. Price — Acting Chief Nursing Officer
- M. Lang — Interim Clinical Nursing Director
- P.Rodriguez — Nursing Quality Improvement
- E.Bradley — Risk Management Director
- V. Simpson — Risk Manager
- H. Jones — Director, Health Information Management
- M. McClure — Chief Information Officer
- S. Abrams — Nursing Finance
- L. Russeau — Patient Safety Officer
- M. Villaflor — Medical Staff Coordinator

- Six Performance Improvement Specialists from the Department of Quality Improvement

Regulatory > Prioritized Summary of Recommendations

Structure, Leadership and Oversight		
Urgent	2.4.01	Institute a regulatory readiness committee that meets weekly.
Now	2.4.02	Develop and aggressively implement a detailed action plan.
Urgent	2.4.03	Resurrect/reinvigorate JCAHO Functional Committees.
Urgent	2.4.04	Develop and provide a dashboard of the organization's level of regulatory compliance to the BOS.
Urgent	2.4.05	Ensure that future executive management is educated on regulatory responsibilities.
Urgent	2.4.06	Educate Medical Staff on their responsibilities related to regulatory compliance.
Urgent	2.4.07	Formalize executive patient safety walk rounds.
Urgent	2.4.08	Implement a Human Resource philosophy and policy that recognizes the difference between culpability and blamelessness.Change organizational culture.
Urgent	2.4.09	Coach medical staff division chiefs.
Urgent	2.4.10	Develop expectations and an accountability structure.
Urgent	2.4.11	Provide senior leadership with measures to assess the effectiveness of individuals responsible for the regulatory compliance program.
Urgent	2.4.12	Provide a senior consultant to coach Administrative Director, Quality Management/Regulatory Programs in effectively managing the regulatory compliance process.
Short term	2.4.13	Provide staff with information related to the hospitals' philosophy regarding regulatory compliance.
Urgent	2.4.14	Develop and maintain a system to track all licensures/certifications/accreditations in a central repository.
Urgent	2.4.15	Revise the Regulatory compliance reporting structure.

Now (Dec) Urgent (Jan--Feb) Short term (2-6 months) Intermediate (4-9 months) Long term (>9 months)

Regulatory > Prioritized Summary of Recommendations

Process		
Urgent	2.4.16	Utilize PI Analysts to educate management staff on root cause analysis and strategies to perform objective, critical assessments of organizational performance.
Now	2.4.17	Disseminate the results of regulatory and accreditation surveys to middle management and staff with an assignment of responsibility for corrective actions.
Urgent	2.4.18	Coach management staff to develop substantive corrective actions that treat deficiencies with hard-wired approaches and at the root cause level rather than the symptoms.
Urgent	2.4.19	Structure a formal mechanism to follow-up on corrective actions and to track current status of planned improvements.
Short term	2.4.20	Facilitate coordination and integration between all hospital-wide functions through the encouragement of teamwork and collaboration.
Short term	2.4.21	Revise the hospital-wide staff orientation and ongoing education program.
Short term	2.4.22	Implement a formal process to create, approve, disseminate, educate, and reinforce new or revised policies and procedures, and to assess staff compliance.
Short term	2.4.23	Implement an effort to internally and publicly promote the organization's accomplishments and advances in improving the safety and quality of care.

Regulatory > Compliance Profile

- KDMC's recent regulatory compliance history includes:
  - Preliminary denial of Joint Commission on Accreditation of Healthcare Organizations (JCAHO) accreditation due to a series of surveys with marginal to poor outcomes dating back to February 12, 2004.
  - Loss of JCAHO accreditation is anticipated in mid- to late-January 2005.
  - Recent difficulty with Centers for Medicare and Medicaid Services (CMS) dates back to:
    - January 2004: Complaint Validation survey during which CMS removed JCAHO deemed status and placed KDMC under California Department of Health Services jurisdiction.
    - March 2004: Complaint investigation relating to medication errors. CMS found an immediate threat to patient safety and proceeded with immediate jeopardy termination.
- The organization has been surveyed and inspected by regulatory and accrediting bodies almost monthly over the past 12 months.
- Due to the volume of recent surveys and the subsequent submission of plans of correction to regulatory and accrediting agencies, the organization has been in a reactionary rather than proactive mode as it relates to regulatory preparedness and compliance.
- The organization has committed to implementing volumes of corrective actions with CMS and JCAHO without accountability or tracking mechanisms.

Regulatory > Compliance Profile

- There is a pervasive belief that the organization is being “set up“ for closure through poor reviews by regulatory and accrediting agencies.
- The organization’s staff have assumed the role of victim with respect to regulatory agencies.
- Previously-submitted JCAHO and CMS corrective action plans have not fully addressed the deficiencies. The organization failed to implement, evaluate, reassess and identify measures of success related to the performance of functions and processes that are necessary to continuously improve the quality of patient care.

Regulatory > Structure, Leadership and Oversight

Assessment

- Administrative Director, Quality Management/Regulatory Programs maintains oversight responsibility for the organization's regulatory compliance efforts. As such, all of the hospital's regulatory activities are coordinated by the Administrative Director, Quality Management/Regulatory Programs.
- The Administrative Director, Quality Management/Regulatory Programs has administrative responsibility for:
  - Regulatory compliance
  - Performance Improvement (PI)
  - Hospital policy and procedure development
  - Maintenance and distribution of hospital policies
- Administrative Director, Quality Management/Regulatory Programs administratively reports directly to the Chief Executive Officer.
- The Director's attention is spread over too many programs, resulting in a lack of focus on either PI or Regulatory Compliance.
- The Director feels powerless to execute change and, as a result, has become less effective in her role.
- The Director has not been held accountable for driving improvements within the organization nor has she educated her superiors on the expectations they should set.

Regulatory > Structure, Leadership and Oversight

Assessment

- The director is not effective under the current structure. If focused solely on PI Regulatory Compliance, the director is more likely to be effective. The structure of the regulatory compliance oversight process is as follows:
  - Compliance with JCAHO standards is assessed on an ongoing basis by JCAHO Functional Committees. Each of these multidisciplinary committees is responsible for assessing compliance with an individual chapter of JCAHO standards (a function). Each committee meets monthly and identifies the nature of the organization's non-compliance.
  - The results of these committee's assessments are forwarded to the appropriate departments/staff who are tasked with developing and implementing a plan of correction.
  - These results are also reported to the Ancillary Performance Improvement Committee, which meets quarterly.
  - The results and recommendations are then forwarded onto the Hospital Improving Organizational Performance (IOP) Committee, then onto the Medical Executive Committee and ultimately the Board of Supervisors.

Regulatory > Structure, Leadership and Oversight

Assessment

- Until early 2004, the assessment results emanating from the JCAHO Functional Committees were reported to a Joint Commission Oversight and Assessment Committee rather than the Ancillary Performance Improvement Committee. This committee was disbanded by hospital leadership as its function was perceived to be redundant with that of the Ancillary Performance Improvement Committee.
- The agenda of the Ancillary Performance Improvement Committee is routinely overloaded with reports on individual performance improvement efforts as well as reports from the JCAHO Functional Committees, resulting in lengthy meetings.
- The effectiveness of the JCAHO Functional Committees has diminished over the past few years due to the increased turnover of the staff who participate in these committees.
- The established structure calls for departments to provide quantitative feedback to the JCAHO Functional Committees on their success in implementing improvements and a trending of their performance in that area.
- The assessments of the JCAHO Functional Committees have not been acted upon due to weak leadership at the department manager level. Lack of follow-through in developing and implementing plans of correction was especially evident with the nurse managers and the Chief Nurse Executive.

Regulatory > Structure, Leadership and Oversight

Assessment

- Current regulatory compliance reporting structure.

Compliance with JCAHO standards is assessed by JCAHO Functional Committees

\/

Results reported to ***Ancillary Performance Improvement Committee (quarterly)***

\/

Results and recommendations forwarded to Hospital Improving Organizational Performance (IOP) Committee

\/

Medical Executive Committee

\/

Board of Supervisors

Regulatory > Structure, Leadership and Oversight

Assessment

- Previous senior management has provided minimal leadership to the organization's regulatory compliance efforts.
  - There has been little support and assistance by senior management for requests by the various committees to follow-up with departments on the status of implementing plans of correction.
  - Previous interim senior management has not been aggressive in holding middle management accountable for providing evidence of improvement or for compliance with regulatory and accreditation requirements.
  - Such efforts have been further hampered by frequent and significant turnover of organizational leadership at the senior level and the lack of stable, effective leadership within Nursing and other hospital departments.
- The regulatory compliance function and hospital departmental operations are divorced from one another.
  - Information does not flow into the regulatory compliance process from hospital operations.
  - The department managers are not held accountable for regulatory compliance.
- The Medical Staff department chairs, though formally reporting through the hospital Chief Medical Officer, are held directly accountable by the Dean.

Regulatory > Structure, Leadership and Oversight

Assessment

- Though interested in clinical medicine and committed to providing quality care, the department chairs place greater emphasis on academic endeavors than on oversight of individual physician performance.
- An organizational culture exists that assigns blame to and rationalizes medical error rather than emphasizing error reduction and embracing a non-punitive environment.
  - The organization lacks a well-defined approach towards balancing individual accountability with system or process failures.
  - There has been little or no education of hospital staff on efforts to improve patient safety.
- Due to the volume of recent surveys and the subsequent submission of plans of correction, the organization has fallen into a defensive position with regulatory agencies and has not been proactive in assuring regulatory compliance.
- Responsibility for maintaining and tracking all of the organization's licenses, certifications, and accreditations has not been centralized.
- The Los Angeles County Department of Health Services has an Office of Quality Improvement, which can provide minimal support in helping the organization achieve regulatory compliance.
  - In the past, staff from this office have lent an objective eye to help the organization assess its compliance with regulatory requirements.
  - This service is currently not being utilized by KDMC.

Regulatory > Structure, Leadership and Oversight

Deficiencies

- Ineffective structure supporting the regulatory compliance function as evidenced by the impending loss of JCAHO Accreditation and requirement to enter into a memorandum of understanding (MOU) with CMS and continued failure to assure the organization's continued compliance with regulatory requirements.
- Lack of coordination with Charles R. Drew School of Medicine and response to the recommendations, requirements and citations of their Graduate Medical Education residency review committees.
- Lack of oversight by previous senior management and the Board of Supervisors of the quality of care and compliance with regulatory and accreditation requirements.
- Failure to integrate the regulatory compliance process into hospital operations and performance improvement goals.
- Lack of accountability of Medical Staff department chairs for individual and collective physician performance.
- Failure to make patient safety and continuous quality improvement a priority in the eyes of hospital and medical staff.
- Reactive rather than proactive approach with respect to regulatory compliance.
- Lack of an organized system to maintain and track all of the organization's licenses, certifications, and accreditations in a central repository and the assignment of responsibility for each.

Regulatory > Structure, Leadership and Oversight

Recommendations

2.4.1 Institute a regulatory readiness committee that meets weekly.

- This Committee will be chaired by the Chief Operating Officer and staffed by the Administrative Director, Quality Management/Regulatory Programs. Membership will include executive management, the Medical Staff, Nursing, Human Resources, and representatives of the Ancillary/Support IOP Committee.
- The Committee's charge would be to track the organization's progress in achieving compliance with regulatory requirements, prepare for regulatory surveys, and to hold individuals accountable for continuous compliance.
- Progress reports will submitted to the IOP Committee monthly, with reports to the Medical Executive Committee also occurring monthly.

Regulatory > Structure, Leadership and Oversight

Recommendations

2.4.2 Develop and aggressively implement a detailed action plan that identifies and resolves regulatory deficiencies identified by JCAHO, CMS, and NCI consultants. Resolution of deficiencies will address the systemic causes of non-compliance and include:

- Policy and procedure development
- Staff education
- Implementation of new and revised practices
- Use of performance measures to gauge improvements
- Daily tracking of progress in fulfilling the Action Plan with reporting to Hospital's senior management on a weekly basis

2.4.3 Resurrect/reinvigorate JCAHO Functional Committees (mock survey standards teams).

2.4.4 Develop and provide a dashboard of indicators on the organization's level of regulatory compliance to the Board of Supervisors.

Regulatory > Structure, Leadership and Oversight

Recommendations

2.4.5 Ensure that future executive management is educated on their responsibilities relative to regulatory compliance, performance improvement and health care safety through:

- Executive coaching
- Education on regulatory requirements
- Establishing and fulfilling accountabilities surrounding regulatory compliance; and
- Providing a consistent flow of information on the organization's level of regulatory compliance.

2.4.6 Educate Medical Staff on their responsibilities related to regulatory compliance.

2.4.7 Formalize executive patient safety walk rounds, including a formal feedback mechanism, to promote an organizational culture of safety.

Regulatory > Structure, Leadership and Oversight

Recommendations

2.4.8 Implement a Human Resources philosophy and policy that recognizes the differences between individual culpability and blamelessness, such as that described by James Reason in "Managing the Risks of Organizational Accidents" (see attached algorithm page 60).

- Educate frontline managers who deal with errors and provide staff with feedback on efforts to reduce the risk of error.

2.4.9 Coach medical staff division chiefs to assess individual physician performance and to initiate appropriate action. The use of external reviewers will be used, as appropriate.

2.4.10 Develop expectations and an accountability structure to hold middle management accountable for regulatory compliance, patient safety and performance improvement.

2.4.11 Provide senior leadership with measures to assess the effectiveness of individuals responsible for the regulatory compliance program.

- Identify qualities of an effective regulatory compliance process.

Regulatory > Structure, Leadership and Oversight

Recommendations

2.4.12 Provide a senior consultant to coach Administrative Director, Quality Management/Regulatory Programs in effectively managing the regulatory compliance process.

2.4.13 Provide staff with information and education related to the hospitals' philosophy that regulatory compliance is a natural result of effective hospital operations and management and not a stand-alone activity.

2.4.14 Develop and maintain a system to track all licensures/certifications/accreditations in a central repository in the quality department. Identify individuals responsible for compliance with each regulatory body.

Regulatory > Structure, Leadership and Oversight

Recommendations

2.4.15 Revise the regulatory compliance reporting structure.

NAVIGANT CONSULTING

Regulatory > Process

Assessment

- The organization's internal assessment of its performance has failed to identify and proactively respond to significant lapses in compliance with regulatory requirements.
- Information on the organization's performance on regulatory surveys has been closely held by senior management. Department management have not been involved in the development of the corrective action plan and have not had the opportunity to provide suggestions for process improvements.
- Development of superficial corrective actions with lack of follow-through on identified corrective actions and mechanism to track current status of planned improvements.
- Deterioration in the organization's ability to adhere to established policies, procedures, and systems.
- Ineffective hospital-wide staff orientation and ongoing education system.
- Lack of reports to the Board of Supervisors that capture pertinent quality/patient safety activities of the organization.
- Performance of the systems, processes, and infrastructure that supports the organization's ability to satisfy regulatory and accreditation requirements has deteriorated over time.
- Attention to basic clinical practice and staff competence has declined over time.
- There is a public and professional perception that quality is poor and will not change.

Regulatory > Process

Deficiencies

- Lack of a critical self-assessment of organizational performance.
- Department management is not engaged in resolving deficiencies cited by regulatory agencies.
- The organization has not been successful in implementing correction action plans developed in response to regulatory and accreditation surveys.
- The effectiveness of the organization's PI initiative and infection control effort has diminished over time.
- Lack of coordination and integration between hospital-wide functions, such as infection control, risk management and performance improvement.

Regulatory > Process

Recommendations

2.4.16 Utilize PI Analysts to educate management staff on root cause analysis and strategies to perform objective, critical assessments of organizational performance.

2.4.17 Disseminate results of regulatory and accreditation surveys to middle management and staff with an assignment of responsibility for corrective actions.

2.4.18 Coach management staff to develop substantive corrective actions that treat deficiencies with hard-wired approaches and at the root cause level rather than the symptoms.

2.4.19 Structure a formal mechanism to follow-up on corrective actions and to track current status of planned improvements.

2.4.20 Facilitate coordination and integration between all hospital-wide functions through the encouragement of teamwork and collaboration.

2.4.21 Revise the hospital-wide staff orientation and ongoing education program.

2.4.22 Implement a formal process to create, approve, disseminate, educate and reinforce new or revised policies and procedures, and to assess staff compliance.

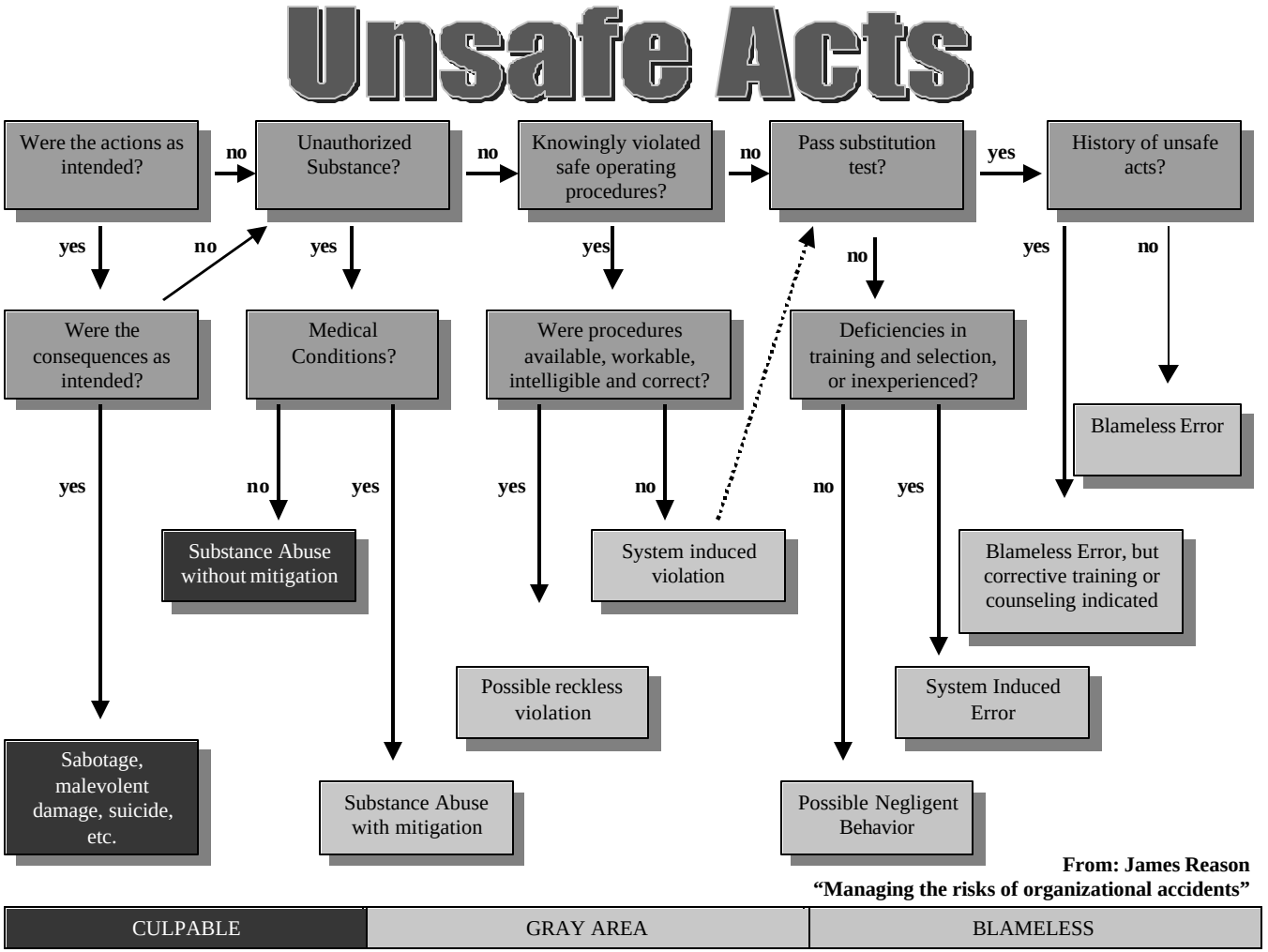
2.4.23 Implement an effort to internally and publicly promote the organization's accomplishments and advances in improving the safety and quality of care.

Regulatory

Responsibility

- CEO
- Administrative Director, Quality Management/Regulatory Programs

Managing the Risks of Organizational Accidents



NAVIGANT CONSULTING

Section II – General Operations/Organizational Structure

5. Performance and Quality Improvement
   - Interviews
   - Prioritized Summary of Recommendations
   - Leadership, Management and Oversight
   - Staffing and Process
   - Tools, Measurement and Technology
   - Patient Satisfaction

Performance and Quality Improvement > Interviews

• L. Knight	Administrative Director, Quality Management/Regulatory Programs
• R. Peeks, MD	Medical Director
• P. Valenzuela	Lead Administrator, Ancillary & Rehab Services
• P. Price	Acting Chief Nursing Officer
• M. Lang	Interim Clinical Nursing Director
• P. Rodriguez	Nursing Quality Improvement
• E. Bradley	Risk Management Director
• V. Simpson	Risk Manager
• H. Jones	Director, Health Information Management
• M. McClure	Chief Information Officer
• S. Abrams	Nursing Finance
• L. Russeau	Patient Safety Officer
• M. Villaflor	Medical Staff Coordinator
• M. Hernandez	Former COO
• F. Robinson	ITC / Nursing Administration

Performance and Quality Improvement > Interviews

- S. Mitchell — Staff / Nursing Administration
- C. Nalls — Ambulatory Care Administration
- J. Johnson — Staff / Ambulatory Administration
- C. Cahill — Materials Management / Olive View Medical Center

- Six Performance Improvement Specialists from Department of Quality Improvement

Performance and Quality Improvement > Prioritized Summary of Recommendations

Leadership, Management and Oversight		
Urgent	2.5.01	Develop a quality oversight committee of the Board.
Urgent	2.5.02	At a minimum, revise IOP Committee membership to a 15 member group that assesses departmental PI reports.
Urgent	2.5.03	Develop and educate IOP Committee members on their responsibilities and charge.
Urgent	2.5.04	Separate out administrative responsibility for Regulatory Compliance from PI, each with a unique manager.
Urgent	2.5.05	Appoint a member of the medical staff to fulfill the Medical Safety Officer role.
Urgent	2.5.06	Charge a physician and advanced practice nurse to oversee core measure activities.
Urgent	2.5.07	Establish a PI manager role to facilitate oversight of department functions.
Urgent	2.5.08	Ensure there is a functioning, formal process and forum for reporting of sentinel events and root cause analyses.
Urgent	2.5.09	Realign reporting relationships of PI Director and Risk Manager.
Urgent	2.5.10	Establish a mechanism for dissemination of information from the IOP Committee to appropriate departments.
Urgent	2.5.11	Revise the Performance Improvement Plan to include the missing issues.
Urgent	2.5.12	Educate directors and managers on their PI responsibilities.
Urgent	2.5.13	Review and update Hospital Plan for the provision of care and departmental scopes.
Staffing and Process		
Urgent	2.5.14	The proposed structure of the hospital-wide IOP Committee is shown in this report.
Urgent	2.5.15	Educate department management and staff on essential PI tools and strategies.
Urgent	2.5.16	Define accountabilities with middle managers related to PI.
Short term	2.5.17	Identify a clear charge to all PI teams and monitor their progress.
Urgent	2.5.18	Require each department to have PI as part of their department meeting discussion.
Short term	2.5.19	Incorporate educator position into quality department or train PI specialists to educate hospital-wide staff on PI tools.
Short term	2.5.20	Provide standardized education to all levels of staff on PI goals.

Now (Dec) Urgent (Jan -Feb) Short term (2-6 months) Intermediate (4-9 months) Long term (>9 months)

Performance and Quality Improvement > Prioritized Summary of Recommendations

Staffing and Process		
Urgent	2.5.21	Review and/or revise the policies on the National Safety goals.
Short term	2.5.22	Develop Human Resource staffing measures.
Urgent	2.5.23	Develop oversight for an organized and systematic approach to performance measurement in Nursing.
Urgent	2.5.24	Pilot a new method of starting PI on a nursing unit to evaluate the process.
Short term	2.5.25	Revise the PI model based on the pilot results and implement the model on all units.
Urgent	2.5.26	Assign Nursing department responsibility for data collection and analysis relative to restraint use.
Short term	2.5.27	Establish regular meeting with Nursing and the newly-designated hospital PI coordinator to assure that nursing is measuring their performance on the appropriate indicators and that the data is being assessed and used to improve performance.
Short term	2.5.28	Provide instruction to staff on reportable errors. Create a non-punitive culture to encourage self-reporting.
Short term	2.5.29	Educate staff on their responsibilities related to organ procurement.
Short term	2.5.30	Provide initial and ongoing staff education for performance improvement and medical safety activities.
Urgent	2.5.31	Identify all opportunities for a root cause analysis to the PI department in a timely manner (as soon as they happen).
Short term	2.5.32	Hold division chiefs accountable for evaluating physician performance and making reappointment recommendations.
Urgent	2.5.33	Assign responsibility for processes that cross departmental boundaries and lack an identified owner.
Short term	2.5.34	Provide administrative and data support to the peer review process.
Short term	2.5.35	Evaluate the effectiveness of Medical Staff Department PI efforts.
Short term	2.5.36	Conduct a formal review and mentor the process of all case reviews.
Short term	2.5.37	Retrain and mentor all of the QI/PI analysts, as well as chairs, in what is expected and how to accomplish.
Short term	2.5.38	Mentor QI?PI analysts.

Performance and Quality Improvement > Prioritized Summary of Recommendations

Tools, Measurement and Technology		
Short term	2.5.39	Implement the use of standardized PI tools.
Short term	2.5.40	Develop forms for the monthly reporting of data and easy reading of the data.
Short term	2.5.41	Develop a measure for patient falls and establish a rate.
Short term	2.5.42	Develop a daily multidisciplinary tool for compliance assessment and other JCAHO/CMS citations.
Short term	2.5.43	Educate nursing on measuring process.
Short term	2.5.44	Begin to track and trend risk management data.
Short term	2.5.45	Develop a tool to measure reporting of all deaths within two-hour timeframe.
Urgent	2.5.46	Standardize the performance measurement process by implementing scientific methodology to develop measures.
Short term	2.5.47	Implement a PI data analysis system.
Urgent	2.5.48	Review departmental staffing to provide for a data analyst position within the existing staffing complement.
Short term	2.5.49	Investigate use of program to collect, classify, manage and analyze data.
Short term	2.5.50	Investigate cost of Statistical Process Control Software Programs for use.
Short term	2.5.51	Investigate use of the Plato Data Analyzer Program.
Short term	2.5.52	Use Cactus computer program module in medical staff office for physician peer review.
Short term	2.5.53	Investigate using Nursing Data Indicator Quality Program.
Urgent	2.5.54	Measure and track compliance to the National Patient Safety goals and measures.

Performance and Quality Improvement > Prioritized Summary of Recommendations

Patient Satisfaction - Surveys		
Urgent	2.5.55	Establish formal leadership responsibility along with logistics in result report distribution and follow-up process.
Urgent	2.5.56	Investigate an opportunity to utilize an outside vendor to measure patient satisfaction.
Urgent	2.5.57	Investigate with DHS the use of a consistent vendor across all county facilities to facilitate peer hospital comparisons.
Urgent	2.5.58	Utilize the County-wide outpatient survey result available for individual hospitals.

Performance and Quality Improvement > Leadership, Management and Oversight

Assessment

- Administrative Director, Quality Management/Regulatory Programs has administrative responsibility for:
  - Regulatory compliance
  - Performance Improvement (PI)
  - Hospital policy and procedure development
  - Maintenance and distribution of hospital policies
- Administrative Director, Quality Management/Regulatory Programs administratively reports directly to the Chief Executive Officer.
- The Director's attention is spread over too many programs, resulting in a lack of focus on PI.
- The Director feels powerless to execute change and, as a result, has become less effective in her role.
- The Director has not been held accountable for driving improvements within the organization nor has she educated her superiors on the expectations they should set.
- The Director is not effective under the current structure. If focused solely on PI or Regulatory Compliance, the director is more likely to be effective.
- The Medical Safety Officer role is currently being held by one of the PI specialists.
  - The county is to appoint a Medical Safety Officer for each of the county hospitals.

Performance and Quality Improvement > Leadership, Management and Oversight

Assessment

- Nursing has a separate function that went several months without reporting to the PI Committee.
- Integration and coordination of Risk Management activities with PI is not occurring.
- The PI Plan describes the scope, structure, objectives, methodology, and evaluation of the PI process. While the plan addresses the essential elements, it does not reflect a current approach to PI.
- The hospital plan for the provision of care and department scopes of care were last revised and approved by the executive team in 2003.
- New PI initiatives are not established and assigned a strategic priority by a single source within the organization.
- Data is not being reported into the PI committees.
- There is no mechanism to identify, inform senior management and respond to unanticipated events.
- Executive staff and middle management staff are having difficulty in getting access to incident reports and aggregate data.

Performance and Quality Improvement > Leadership, Management and Oversight

Assessment

- The current structure of the hospital-wide Improving Organizational Performance (IOP) Committee is as follows:

Feature	Current Structure
Membership Size	50 members
Membership	All clinical areas (both Medical Staff and non-medical staff departments).
Attendance	All 50 members attend each monthly meeting.
Reporting	Departments report on the outcomes of their PI efforts and on variances in practice on a rotating basis.
Information Flow	The results of the IOP Committee are presented to the Medical Executive Committee on a **quarterly** basis and subsequently to the Board.

Performance and Quality Improvement > Leadership, Management and Oversight

Assessment

- A PI Analyst is assigned to assist those departments that are struggling with implementing a change.
- The organization's core measures are:
  - Community-Acquired Pneumonia
  - Acute Myocardial Infarction
  - Congestive Heart Failure
- The summary results of core measure data are reported to the Medical Executive Committee and the respective medical staff departments. No actions are taken in response to this data.

Performance and Quality Improvement > Leadership, Management and Oversight

Deficiencies

- The PI Program is not well defined, ongoing and implemented.
- The program is fragmented in different departments and is not organization-wide.
- There is an absence of an effective quality committee of the Board to provide oversight of the hospital IOP Committee.
- Lack of effective oversight and accountability of PI Program.
- Risk Management, Safety and PI activities are not well coordinated.
- Lack of oversight by Nursing department staff for PI indicators pertaining to Nursing.
- With 50 members, the size of the hospital-wide IOP Committee is unwieldy and does not hold individuals accountable for improvements.
- The hospital plan for the provision of care and department scopes of care are now considered outdated.

Performance and Quality Improvement > Leadership, Management and Oversight

Recommendation

2.5.1 Develop a quality oversight committee of the Board (or enhance existing IOP Committee), with a clear charge and well-defined responsibilities. Require that all measurement initiatives report through it.

2.5.2 At a minimum, revise IOP Committee membership to a 15 member group that assesses departmental PI reports. Majority of department representatives would only attend those meetings at which they are scheduled to present.

2.5.3 Develop and educate IOP Committee members on their responsibilities and charge.

2.5.4 Separate out the administrative responsibility for Regulatory Compliance from PI, each with a unique manager. Transition Performance Improvement activities to Medical Administration with a Director of Performance Improvement and supporting QM staff reporting to the AMD for UM and Clinical Programs.

2.5.5 Appoint a member of the medical staff to fulfill the Medical Safety Officer role.

2.5.6 Charge a physician and advanced practice nurse to oversee core measure activities.

2.5.7 Establish a PI manager role to facilitate oversight of department functions and provide a senior consultant to coach this individual in their new role.

Performance and Quality Improvement > Leadership, Management and Oversight

Recommendation

2.5.8 Ensure there is a functioning, formal process and forum for the reporting of Sentinel events and root cause analyses. Add this and other health care safety issues as standing agenda items to the IOP and Board Committee.

2.5.9 Realign the reporting relationships of the PI Director and Risk Manager to report through the same administrative hierarchy in order to improve the collaboration between these two functions.

2.5.10 Establish a mechanism for dissemination of information from the IOP Committee to appropriate departments.

2.5.11 Revise the PI Plan to include the missing issues.

2.5.12 Educate directors, managers on their PI responsibilities.

2.5.13 Review and update the Hospital Plan for the provision of care and departmental scopes.

Performance and Quality Improvement > Staffing and Process

Assessment

- Staffing of Quality Management/Regulatory Programs department consists of:
  - 1 Director
  - 6 PI Analysts
    - Five of the six analysts have achieved Certified Professional in Healthcare Quality (CPHQ) status from the Healthcare Quality Certification Board of the National Association for Healthcare Quality (NAHQ).
  - 1 Clerk
  - The analysts' responsibilities include:
    - Abstracting and reviewing clinical documentation for performance improvement studies.
    - Identifying cases for peer review.
    - Initiating and coordinating root cause analyses.
  - Each analyst has responsible for coordinating the performance improvement activities of at least one medical staff department.
  - The analysts are generally competent at performing their activities.
  - By comparison with with 200-bed facilities, the Quality Management/Regulatory Programs department is overstaffed.

Performance and Quality Improvement > Staffing and Process

Assessment

Current PI Process

- The organization uses the Focus PDCA performance improvement model to plan, design, measure, and improve patient care and processes.
- The important key functions to be monitored and evaluated are to be identified in each department.
- Department heads/service chiefs are to assist their department staff in selecting key functions or services to be evaluated in departmental PI activities.
- Additionally, key functions or services are to be identified for improvement in an interdisciplinary setting (e.g., medical staff committees or task forces).
- Priorities for organizational PI activities are to be established collaboratively by organizational leadership.
- Data collection is to consist of selecting:
  - Data source(s)
  - Data collection method
  - Appropriateness of sampling
  - Time frame for data collection
  - Process for comparing the level of performance

Performance and Quality Improvement > Staffing and Process

Assessment

Current PI Process

- Empirical data is to be collected to determine if:
  - Design specification of a new process was met.
  - Level of performance and stability of important existing processes.
  - Priorities for possible improvement of existing processes.
  - Actions to improve the performance pf processes.
  - Whether changes in the process resulted in improvement.
- Data is to be collected and reported monthly on PI initiatives.
- For interdisciplinary PI efforts, the PI Committee is to determine which department will coordinate the data collection.
- Statistical quality control techniques and variation are to be used when appropriate.
- Absolute levels of benchmarks based on appropriate standards are to be utilized in evaluating important single clinical events or in identifying the level or patterns/trends in care or outcomes.

Performance and Quality Improvement > Staffing and Process

Assessment

Current PI Process

- The following processes and clinical activities are to be measured and assessed when an undesirable variation in performance is detected:
  - Discrepancies or patterns of discrepancies between preoperative and postoperative diagnosis.
  - Transfusion reactions.
  - Adverse events, or patterns of adverse events during anesthesia use.
  - Behavior management processes and outcomes.
- Opportunities to improve care or service identified through departmental monitoring is to be addressed at departmental meetings, documented as such, and integrated into organizational PI activities.
- Opportunities to improve care/service identified through interdisciplinary meetings are addressed and documented in committee meeting minutes.
- The PI Committee reviews and prioritizes all such recommendations and makes the determination to assign a process action team to identify and implement actions to improve the process.
- All information generated through this PI Process is reported through the monthly IOP Committee.

Performance and Quality Improvement > Staffing and Process

Assessment

Current PI Process

- The results of PI efforts are to be disseminated throughout the organization through:
  - Governing Body meeting minutes
  - Medical Executive Committee
  - Medical Staff Service/IOP Committee meetings
  - Story Boards
  - Process Action Team Committee minutes, process improvement team, department and services staff meetings
  - Management information bulletins
- Actions taken are to be assessed for effectiveness through continued monitoring.
- The effectiveness of actions taken is to be documented on the hospital-wide reporting tool and in appropriate departmental and committee meeting minutes.
- The information is then to be shared throughout the organization.
- Data is collected but not trended.
- The validity of the data is suspect.

Performance and Quality Improvement > Staffing and Process

Assessment

- Outcomes, improvements and method to decrease adverse events are not occurring. There is a demonstrated lack of improvement noted with patient assessments:
  - Nutrition not being consistently assessed or referred to dietary.
  - Inconsistent pain assessment and reassessment.
  - Wound management not being carried out.
- Nursing indicators focused on patient outcomes for restraint use are lacking.
- The Nursing PI function reports through the hospital-wide PI Process.
- There is minimal reporting of medication errors by nursing staff. Medication errors are most frequently identified and reported by the Pharmacy staff and reflect errors in ordering.
- The organization cannot compute a patient fall rate from available data.
- The hospital was cited for lack of compliance with all seven patient safety goals.
- There is no tracking mechanism to measure and assure that deaths are reported to the organ procurement agency. A review of medical records from January to May 2004 found two cases, which had a potential for organ procurement, that were not referred to the organ procurement organization.

Performance and Quality Improvement > Staffing and Process

Assessment

- Staffing effectiveness measures have not been developed nor has data been analyzed for this purpose.
- The effectiveness of the Medical Staff department PI efforts is unknown.
- Root cause analyses do not reflect a thorough, credible process.
- Many root cause analyses were conducted but there is not a summary of the outcomes. It is unclear whether the measures developed to monitor the effectives of the outcomes are happening or where they are being reported, if reported. The events are not trended.
- The approach to scientific process for performance measurement not developed. (Frequency of data collection not specified, lack of data aggregation and analysis and identification of opportunities for improvement).
- The hospital patient identifiers are conflicting. For adults, patient's name and medical record number is used. For Pediatrics, patient's name and date of birth is used. Staff understanding of these identifiers contradicts that which is stated in policy.
- There are generic screen referrals. Each department has specific indicators to trigger a physician review. A review of Medical Staff department meeting minutes reflects that peer review is occurring in all services.

Performance and Quality Improvement > Staffing and Process

Assessment

- The Medical Staff credentialing, privileging and reappointment process does not result in an objective assessment of individual practitioners' performance.
- The Medical Staff Peer Review process is not functional and does not contribute to improving the quality of care.
- Medical staff peer review activities are not being recorded in the physician profile.
- Data on core measures is not being well disseminated to staff.
- The results of PI efforts, advances in patient safety, and the organization's priorities for improvement, are not communicated by middle management to front-line staff.

Performance and Quality Improvement > Staffing and Process

Deficiencies

- The PI Program is data rich/information poor.
- There is a lack of data aggregation, analysis and identification of opportunities for improvement.
- There is a lack of follow-through on implementing recommendations for improvement.
- There is a lack of communication throughout the organization, including feedback on PI and patient safety issues (dead-ends with middle management).
- The peer review process does not identify individual medical staff member performance issues, which are to be fed into the clinical privileging and reappointment process.
- There is inadequate staff education for quality and medical safety activities.

Performance and Quality Improvement > Staffing and Process

Recommendation

2.5.14 The proposed structure of the hospital-wide IOP Committee is as follows:

Feature	Proposed Structure
Membership Size	15 members.
Membership	Select medical staff, clinical, and administrative leaders.
Attendance	In addition to the IOP Committee members, only representatives of departments reporting that month attend.
Reporting	Same.
Information Flow	The results of the IOP Committee are presented to the Medical Executive Committee on a **monthly** basis and subsequently to the Board.

Performance and Quality Improvement > Staffing and Process

Recommendation

2.5.15 Educate department management and staff on essential PI tools and strategies including:

- How to measure performance.
- Aggregate and analyze data.
- Identify and implement opportunities for improvement.
- Measure performance to assess the effect of the improvement on outcomes.

2.5.16 Define accountabilities with middle managers related to PI.

2.5.17 Identify a clear charge to all PI teams and monitor their progress.

2.5.18 Require each department to have PI as part of their department meeting discussion.

2.5.19 Incorporate the role of an educator position into the quality department or train all the PI specialists to educate hospital-wide staff on PI tools.

2.5.20 Provide standardized education to all levels of staff on PI goals.

2.5.21 Review and/or revise the policies on the National Safety goals.

2.5.22 Develop Human Resource staffing measures.

Performance and Quality Improvement > Staffing and Process

Recommendation

2.5.23 Develop oversight for an organized and systematic approach to performance measurement in Nursing. This will include:

- Monitoring of performance through data collection.
- Analysis of current performance.
- Reduction of unacceptable variation.

2.5.24 Pilot a new method of starting PI on a nursing unit to evaluate the process.

2.5.25 Revise the PI model based on the pilot results and implement the model on all units.

2.5.26 Assign the Nursing department responsibility for data collection and analysis relative to restraint use.

2.5.27 Establish regular meeting with Nursing and the newly-designated hospital PI coordinator to assure that nursing is measuring their performance on the appropriate indicators and that the data is being assessed and used to improve performance.

2.5.28 Provide instruction to staff on reportable errors. Create a non-punitive culture to encourage self-reporting.

2.5.29 Educate staff on their responsibilities related to organ procurement.

2.5.30 Provide initial and ongoing staff education for performance improvement and medical safety activities.

Performance and Quality Improvement > Staffing and Process

Recommendation

2.5.31 Identify all opportunities for a root cause analysis to the PI department in a timely manner (as soon as they happen.) PI will assign responsibility for oversight and assuring measures and outcomes occur.

2.5.32 Hold division chiefs accountable for evaluating physician performance and for making objective recommendations for reappointment. Add to each physician profile, the number of cases, average LOS, adjusted LOS, mortality rate, adjusted mortality rate, readmit rate and adjusted readmit rate (numbers should come from finance).

2.5.33 Assign responsibility for processes that cross departmental boundaries and lack an identified owner.

2.5.34 Provide administrative and data support to the peer review process.

2.5.35 Evaluate the effectiveness of Medical Staff department performance improvement efforts.

2.5.36 Conduct a formal review and mentor the process of all case reviews (actual peer review session and/or root cause analysis sessions).

2.5.37 Retrain and mentor all of the QI/PI analysts, as well as chairs, in what is expected and how to accomplish.

2.5.38 Mentor QI/PI analysts.

Performance and Quality Improvement > Tools, Measurement and Technology

Assessment

- Incident Report tracking is performed manually. Reports are lost and do not reach the Risk Management department.
- PI department staff primarily use word processing software. Spreadsheet use is unfamiliar territory.
- There is a high level of manual manipulation of PI data.
- The county is working on an electronic version of an incident tracking system, but the date for completion has not been specified. KDMC will be a pilot site.
- The MIDAS system was previously used to analyze PI data. Glitches in the system caused senior management to decide against purchasing upgrades of this system. Use of the system was subsequently abandoned.
- The hospital-wide Affinity system does not track the follow-up performed or information on individual risk management events.
- A recent enhancement installed by the organization's performance measurement system vendor (University Healthcare Consortium) provides attending physician-specific data on performance of core measure activities. This feature will provide peer review data for the credentialing and privileging process.

Performance and Quality Improvement > Tools, Measurement and Technology

Deficiencies

- Lack of a system to analyze PI data.
- Lack of a system to analyze risk management events.
- Computer skills of PI analysts is minimal.
- Poor coordination with Risk Management.

Performance and Quality Improvement > Tools, Measurement and Technology

Recommendation

2.5.39 Implement the use of standardized PI tools.

2.5.40 Develop forms for the monthly reporting of data and easy reading of the data.

2.5.41 Develop a measure for patient falls and establish a rate.

2.5.42 Develop a daily multidisciplinary tool for compliance assessment, (e.g., abbreviations, pain assessment and reassessment, I&0s, completeness of assessment, nutritional referrals to dietary), and other JCAHO/CMS citations.

2.5.43 Educate nursing on measuring process.

2.5.44 Begin to track and trend risk management data.

- Follow the new PI development and methodology process.
- Report data through the PI structure.
- Facilitate the Risk Management staff working more closely with PI staff to reduce error and improve processes.

2.5.45 Develop a tool to measure reporting of all deaths within two-hour timeframe.

2.5.46 Standardize the performance measurement process by implementing a scientific methodology to develop measures.

2.5.47 Implement a PI data analysis system.

Performance and Quality Improvement > Tools, Measurement and Technology

Recommendation

2.5.48 Review departmental staffing to provide for a data analyst position within the existing staffing complement. This position will manage databases to support the quality and medical safety initiatives of the organization.

2.5.49 Investigate use of a program to collect, classify, manage and analyze data. The Advanced Incident Management System (AIMS) can be aggregated within the organization and benchmarking can be done regionally and nationally. (This is one of three software programs recommended by the Institute of Medicine (IOM). This product can also be used to manage root cause analysis follow-up.

2.5.50 Investigate the cost of Statistical Process Control (SPC) Software Programs.

- (The SPC program is approximately $90 for one program) for use.

2.5.51 Investigate use of Plato Data Analyzer Program through CPR technologies for clinical data collection, to automate the collection of data for clinical PI studies.

- (The program is approximately $5,000).

2.5.52 Use the Cactus computer program module in medical staff office for physician peer review. PI specialists need to obtain access.

2.5.53 Investigate using the Nursing Data Indicator Quality Program (NDIQP). This will allow nursing to benchmark to itself and nationally to similar hospitals.

2.5.54 Measure and track compliance to the National Patient Safety goals and measures.

Performance and Quality Improvement > Tools, Measurement and Technology

Responsibility

- CEO
- Medical Director
- CNO
- Administrative Director Quality Management/Regulatory Programs

Performance and Quality Improvement > Patient Satisfaction – Inpatient

Assessment

- KDMC has been conducting the inpatient satisfaction survey in-house (not using an outside vendor).
- Survey questionnaire's format is one sheet, double-sided, available in both English and Spanish. It has 46 multiple-choice questions (three types of multiple-choices, depending on type of question: always/sometimes/never, yes/no, or excellent/good/fair/poor) plus two open-ended questions.
- Distribution and collection of the survey questionnaires is done on a daily basis.
- The "Ambulatory Care Service Marketing Representatives" (a.k.a., Unit Clerks) distribute the questionnaires to all patients in the nursing units.
- One patient may have multiple questionnaires over the course of his/her stay.
- The same unit clerks collect the questionnaire the following day.
- The collected questionnaires are then stored in the Nursing Resource office.
- Nursing Administration staff hand counts each question's answer from each survey questionnaire.
  - Nursing Resources office has a scanner, however it has not been used because it is "slower than hand-counting the answers".
  - The same staff calculates the percentage of "always", "yes" or "excellent + good" relative to total number of answers for each question (using traditional calculator, not a spreadsheet).
- The results report has been prepared on a quarterly basis.

Performance and Quality Improvement > Patient Satisfaction – Inpatient

Assessment

- "Trigger point", or a signal for evaluation is a satisfaction measure resulting in less than 85% of "Always", "Yes", or "Excellent + Good".
  - In the 2002-2003 result report, most of the questions including the "Overall Care" were scored equal or higher than 85%.

	Apr - Jun 2003	Jan - Mar 2003	Oct - Dec 2002	Jul - Sep 2002	Apr - Jun 2002	Jan - Mar 2002
Survey Response Rate	20%	19%	16%	18%	23%	17%
Overall Care (multi-choice from Excellent/Good/Fair/Poor): Percentage of "Excellent" and "Good"	N/A	85%	70%	86%	86%	85%

Notes:
- Survey Response Rate = # of surveys completed / # of discharges
- "N/A" means that results have not been tallied (the survey was conducted).
- As of December 2004, No survey results are available since Apr-Jun 2003.

- Since July 2003, no survey results report has been issued, although the survey sheets had been collected and stored in the Nursing Resources office (have not been tallied).
- The survey results for the 4th quarter of 2001 and the 1st thru 4th quarters of 2003 were issued in February 2004 to the CNO and nursing director (not clear if the report was then distributed to any other parties).

Performance and Quality Improvement > Patient Satisfaction – Inpatient

Assessment

- In 2002, the CNO made a request to the executive team that the responsibility of patient satisfaction survey be moved to “someone outside of the nursing” to “ensure unbiased patient satisfaction measure”. The request was then verbally turned down.
- In 2003, the responsibility of compiling the results report was “unofficially transitioned” from an assistant nurse director to a nursing administration staff.
- Currently, there has been no formal leadership responsibility assigned.
- No follow-up process on the result.
- In 2003, Nursing Administration staff made the suggestion to the CNO as well as to the Director of Quality Management to investigate an opportunity to utilize an outside vendor. There was no follow-up from the CNO or the Director of Quality Management.

Performance and Quality Improvement > Patient Satisfaction – Outpatient

Assessment

- For outpatient satisfaction survey, KDMC has had two surveys:
  - In-house Outpatient Satisfaction Survey
  - A County-wide Outpatient Satisfaction Survey (led by CAO, or County Administrative Office)
- The last in-house satisfaction survey was conducted in 2002. No in-house survey was conducted in 2003 or in 2004.
- In January 2004, a county-wide satisfaction survey was conducted by CAO's lead.
  - The county-wide satisfaction survey covered all clinics of all DHS institutions, except for ER.
  - The result was tallied and reported for the total of all DHS institutions. The result was not available for individual health institutions.
  - The result was "not useful for KDMC", as it was impossible to evaluate KDMC's patient satisfaction in particular.
- Until 2002, the in-house satisfaction survey was the Ambulatory Care Administrator's responsibility (not clear if it was a formal assignment).
- Currently, Director of Ancillary and Rehab Services has been a "contact person" for the County-wide survey, as the Director of Ancillary and Rehab Services is part of the DHS Customer Satisfaction Taskforce.
- No follow-up process is in place.

Performance and Quality Improvement > Patient Satisfaction – Deficiencies

Deficiencies

- There is no leadership assignment related to the patient satisfaction.
- There is no evidence of leadership follow-up on the survey result or leadership response to suggestions from the staff (inpatient survey).
  - The survey results have not been reported for >1 year (inpatient survey).
- The outpatient survey results are not available at individual hospital level. Also, it is not clear if the Ancillary and Rehab Services Director's being a contact person means a formal responsibility (outpatient survey).
- There is no process for sharing the result among the leadership as well as staff (both inpatient and outpatient satisfaction).
- While capable of conducting year-to-year comparison, neither of the existing inpatient or outpatient surveys facilitate "peer comparison" to outside hospitals.

Performance and Quality Improvement > Patient Satisfaction – Surveys

Recommendation

2.5.55 Establish formal leadership responsibility along with logistics in result report distribution and follow-up process.

2.5.56 Investigate an opportunity to utilize an outside vendor to measure satisfaction.

2.5.57 Investigate with DHS the use of a consistent vendor across all county facilities to facilitate peer hospital comparisons.

- Potential survey vendors: Press, Ganey Associates, Inc., SF-36, etc.
- Olive View Medical Center has been using Press, Ganey Associates. Pricing of the Olive View Medical Center's "Inpatient Satisfaction Survey Service" is $31,780 for provision of nine months' survey service (October 2003 thru June 2004).
- Also investigate an opportunity to utilize an outside vendor in conducting patient focus groups and/or exit survey (survey by mail may not be the most appropriate for the KDMC patient population).

2.5.58 Make the county-wide outpatient survey result available for individual hospitals.

Responsibility

- COO
- CNO

Patient Satisfaction

Performance Measures

Inpatient

- Percentage survey response rate
  - Current 20% (April – June)
  - Target 100%
- Percentage of surveys indicating “Overall Care” excellent or good
  - Current not currently collected
  - Target TBD

Outpatient

- Percentage of survey response
  - Current not currently collected
  - Target TBD

Section II – General Operations/Organizational Structure

6. Infection Control
   - Interviewees
   - Prioritized Summary of Recommendations
   - Compliance Profile
   - Structure, Leadership and Oversight
   - Process

Infection Control > Interviews

- M. Sutjita, MD — Infection Control
- I. Davis, RN — Infection Control
- A. Preyer, RN — Infection Control
- J. Miller, MD — Occupational Health
- V. Caldwell — Central Services (plus two additional staff members)
- H. Gharanfoli — Respiratory Care
- M. Rogers — Respiratory Care
- A. Groves — Pharmacy Consultant
- L. Knight — Administrative Director, Quality Management/Regulatory Programs
- N. Haye — Manager, Labor & Delivery
- Dialysis Staff Members
- Endoscopy Staff Members
- ENT Staff Members
- Nursing Staff of:
  - Trauma/Surgical ICU
  - Coronary Care Units 4B and 4A
  - Pediatrics
  - Emergency Department

Infection Control > Prioritized Summary of Recommendations

Structure, Leadership and Oversight		
Urgent	2.6.01	Reassign responsibility of infection control from Medical Director to Interim Chief Nursing Officer.
Now	2.6.02	An Infection Control Plan has been drafted.
Urgent	2.6.03	Revise all infection control policies and procedures to be rooted in scientific principle and current CDC guidelines.
Urgent	2.6.04	Reorganize reporting structure of Infection Control Department, convert current physician Director position to a Physician Advisor position. This position would continue to report to the Medical Director.
Urgent	2.6.05	Create position of Infection Control Manager, which could be assumed by one of the existing Infection Control Practitioner (ICP) positions and coach the newly-designated Infection Control Manager in his/her new role
Urgent	2.6.06	Reorganize reporting structure of Infection ICPs to oversight of the Interim Chief Nursing Officer.
Urgent	2.6.07	Report meaningful information to Infection Control Committee on performance of infection control activities.
Urgent	2.6.08	Reduce size of Infection Control Committee to 10-12 members
Urgent	2.6.09	Investigate infection control module that is available with the current IS system. Investigate the purchase and integration of alternative infection control programs, e.g., EpiQuest.

Now (Dec) Urgent (Jan -Feb) Short term (2-6 months) Intermediate (4-9 months) Long term (>9 months)

Infection Control > Prioritized Summary of Recommendations

Process		
Urgent	2.6.10	Eliminate twice yearly house-wide surveillance.
Urgent	2.6.11	Perform ongoing surveillance activities only in the critical care units monitoring all sites for infection.
Urgent	2.6.12	Revise data collection and analysis methods to produce meaningful data on performance of the infection control process.
Urgent	2.6.13	Select two surgical procedures to monitor for Surgical Infection Prevention (SIP).
Urgent	2.6.14	Develop methodology for post-discharge SIP data collection.
Urgent	2.6.15	Develop categories of isolation based on current CDC guidelines (revised guidelines expected in early 2005).
Urgent	2.6.16	Develop process for identification of unanticipated death or major permanent loss of function associated with a health care acquired infection.
Urgent	2.6.17	Follow the scientific process for the development and methodology of indicators.
Urgent	2.6.18	Report infection control findings on a quarterly schedule to the Patient Safety Committee.
Urgent	2.6.19	Assess services provided by the off-site facilities. Determine infection control needs of staff/patients. Determine if practices are standardized and consistent across the institution.
Urgent	2.6.20	Conduct daily surveillance rounds to identify and follow through on elimination of inappropriate infection control practices.
Urgent	2.6.21	Perform annual uniform competency assessment of all employees performing sterilization or high-level disinfection.
Urgent	2.6.22	Develop consistent policies outlining procedure for monitoring all sterilizers, including those located in Pathology and Environmental Services.

Infection Control > Structure, Leadership and Oversight

Assessment

- The Director of the Department is an infectious diseases physician who devotes approximately eight hours per week performing infection control activities. His primary functions include:
  - Conducting rounds on patients with infections, and
  - Statistical analysis of data.
- The Director possesses a sound knowledge of infection control practices, but lacks the understanding of how to apply this knowledge. He is motivated to fulfill his role as Director, but lacks the insight into how to do so. With proper direction and mentoring, he could be effective in helping the Infection Control program achieve its goals.
- Staffing for the Infection Control Department consists of two Infection Control Practitioners (ICPs), one of which acts in a lead capacity. This cadre of ICPs is adequate for the current average daily census (ADC) of 200.
- Only the lead ICP has obtained Association of Professionals in Infection Control (APIC) certification.
- The lead ICP was brought to KDMC in January 2004 to turn around a struggling program.
- Although the lead ICP has an adequate knowledge of basic infection control practices, as evidenced by the program's lack of progress, she has difficulty translating this knowledge into practice and action.

Infection Control > Structure, Leadership and Oversight

Assessment

- The lead ICP is capable of being mentored, although her desire to do so is questionable.
- The lead ICP frequently defers to the second (non-certified) ICP on KDMC-specific infection control activities.
- The second ICP is reported to be near retirement.
- The ICPs report to the Director.
- There is no infection control plan despite repeated instances of this issue being cited by the JCAHO.
- Infection control policies and procedures are redundant, inconsistent with practice, and conflicting.
  - The policies are outdated and do not reflect current Centers for Disease Control and Prevention (CDC) guidelines or current literature.
- All infection control information and data is being manipulated manually.
- The Infection Control Committee is composed of 25-30 members, many of which are members of the medical staff. Attendance is relatively good.

Infection Control > Structure, Leadership and Oversight

Assessment

- A review of Infection Control Committee meeting minutes reflected a lack of understanding of actual practice hospital-wide.
- The Infection Control Committee meeting minutes lack sufficient detail to assess the effectiveness of the Committee.
- The results of Infection Control Committee meetings are forwarded onto the Medical Executive Committee and subsequently to the Board.
- Data from the Infection Control program is reported to the Improving Organizational Performance (IOP) Committee. Such reports consist solely of data and do not reflect any improvements in infection control practices.
- While the committee reporting structure may be sufficient, the substance of the reports is not.

Infection Control > Structure, Leadership and Oversight

Deficiencies

- Lack of a written Infection Control Plan.
- Lack of appropriate infection control policies and procedures.
- An over-sized Infection Control Committee.
- Lack of integration of infection control indicators into the PI process.
- Lack of integration of infection control data analysis and improvements into the hospital's Patient Safety program.
- Lack of inclusion of off-site facilities in the Infection Control program.
- All data is collected, collated, and analyzed manually.
- Ineffective Infection Control Department reporting structure.

Infection Control > Structure, Leadership and Oversight

Recommendations

2.6.1 Reassign responsibility of infection control from the Medical Director to the Interim Chief Nursing Officer.

2.6.2 A succinct Infection Control Plan has been drafted and includes the following:

- A description of prioritized risks.
- A statement of the goals of the Infection Control program.
- A description of the hospital's strategies to minimize, reduce, or eliminate the prioritized risks.
- A description of how the strategies will be evaluated.

2.6.3 Revise all infection control policies and procedures to be rooted in scientific principle and current CDC guidelines.

- Infection control policies and procedures should mirror current practice and be the basis of that practice.
- Infection control policies and procedures need to become more user friendly; facilitate easy employee access to infection control manuals.

Infection Control > Structure, Leadership and Oversight

Recommendations

2.6.4 Reorganize the reporting structure of the Infection Control Department, convert the current Physician Director position to a Physician Advisor position. This position would continue to report to the Medical Director.

2.6.5 Create the position of Infection Control Manager, which could be assumed by one of the existing ICP positions and coach the newly-designated Infection Control Manager in his/her new role.

2.6.6 Reorganize the reporting structure of the ICPs to the oversight of the Interim Chief Nursing Officer.

2.6.7 Report meaningful information to the Infection Control Committee on the performance of infection control activities. Such reports are to reflect actual improvements in infection control practices.

2.6.8 Reduce size of Infection Control Committee to 10-12 members

2.6.9 Investigate the infection control module that is available with the current IS system; Investigate the purchase and integration of alternative infection control programs, e.g., EpiQuest.

Infection Control > Process

Assessment

- There is twice yearly house-wide surveillance.
- Monthly surveillance is currently being conducted in all critical care areas.
- Infection rates are calculated using number of monthly discharges rather than on device days.
- Surgical site infection is being monitored for all operative procedures and being reported by wound class only.
- Only Contact and Respiratory Isolation Precautions are being used in addition to Standard Precautions.
- Non-compliance with CDC guidelines for the prevention of device related bloodstream infections.
- Preparation of IV flush solution from a large volume container. The individual flushes were drawn into unlabeled, undated syringes at the beginning of the shift (information shared with the Pharmacy advisor).
- Inappropriate use of a wooden storage cabinet for disinfected endoscopes (Endoscopy).
- Lack of appropriate work flow pattern in Endoscopy (scopes are cleaned in the “dirty sink”, placed in the scope processor, processed then carried by the “dirty sink” out of the room for storage). No designated hand washing sink in the processing or procedure rooms.

Infection Control > Process

Assessment

- Appropriate protective barriers are not being used for initiation and termination of dialysis (employees are not wearing gowns during this process).
- Instruments that require high-level disinfection are being sent to Central Sterile Processing for sterilization if used for a patient who is known to be HIV positive (separate standard of care).
- Central Sterile Processing is using date-related sterilization practices. Need to move to event-related sterilization process (decreases likelihood of expired items being stored in patient care areas for patient use).
- Currently, a raw rate is being calculated using the number of conversions divided by the number of PPD's planted. No analysis of data was found to indicate that an annual TB Risk Assessment was conducted based on the CDC Guidelines. This assessment determines the institution's overall TB risk, i.e. low, moderate, or high.
- Occupational Health is ordering chest x-rays every two years on employees who are PPD positive (inconsistent with CDC guidelines).
- Food handlers are required to submit annual stool samples for culture and O&P (outdated practice).
- Varicella vaccine is not provided through the Occupational Health Department.

Infection Control > Process

Assessment

- Agency personnel are not required to be assessed by Occupational Health.
- A physician was observed eating at the nurse's station despite a sign which read, "No eating or drinking at the Nurse's Station" on the Pediatric Unit.
- Painting of ceiling tiles is a common practice.
- Consistent and standardized practices for sterilization and high-level disinfection are not being followed.
  - There are fifteen (15) sterilizers located throughout the institution.
  - Oversight for biological monitoring of each sterilizer lies with the area housing the sterilizer.
  - Biological monitoring results are sent to Central Sterile on a daily basis.
  - Inconsistent policies are in place for sterilizer monitoring.
  - High-level disinfection is occurring in multiple areas of the institution, including ambulatory care sites.
  - Monitoring of OPA solution is being conducted and results are being documented.
- Existing infection control data has not been analyzed.
- Due to a flawed surveillance approach, no valid conclusions may be drawn from existing infection control data.

Infection Control > Process

Deficiencies

- Outdated surveillance methodology. Infection rates are calculated using the number of monthly discharges rather than device days.
- Lack of infection control data analysis.
- Data are not being used to manage or improve processes.
- Lack of documented improvements based on analysis of data. Lack of clarity with the existing isolation system.
- Lack of compliance with JCAHO National Patient Safety Goal #7, part B (unanticipated death or major permanent loss of function associated with a health care acquired infection).
- Inappropriate infection control practices, as described in the assessment.

Infection Control > Process

Recommendations

2.6.10 Eliminate twice yearly house-wide surveillance.

2.6.11 Perform ongoing surveillance activities only in the critical care units monitoring all sites for infection.

2.6.12 Revise data collection and analysis methods to produce meaningful data on the performance of the infection control process:

- Utilize device/patient days as appropriate denominator for data collection and analysis.
- Present risk adjusted data for analysis.
- Use external databases for benchmark comparison, (e.g., CDC NNIS).
- Analysis of data should be site specific and detailed.
- Develop control charts for infection indicators.
- Identify and implement improvements based on data analysis.

2.6.13 Select two surgical procedures to monitor for Surgical Infection Prevention (SIP). This will include: selection of appropriate prophylactic antibiotic, timeliness of prophylactic antibiotic administration, appropriate discontinuation of prophylactic antibiotic, development of surgical site infection.

2.6.14 Develop methodology for post-discharge SIP data collection.

Infection Control > Process

Recommendations

2.6.15 Develop categories of isolation based on current CDC guidelines (revised guidelines expected early 2005).

- Delete the category of Respiratory Isolation and replace it with Airborne Precautions and Droplet Precautions.
- Droplet Precautions do not require patients to be placed in negative air pressure rooms or the use of the more expensive N95 respirators for employee respiratory protection.
- Increased appropriate isolation for patients with documented or suspect TB due to a greater availability of negative pressure rooms.

2.6.16 Develop a process for identification of unanticipated death or major permanent loss of function associated with a health care acquired infection.

2.6.17 Follow the scientific process for the development and methodology of indicators.

2.6.18 Report infection control findings on a quarterly schedule to the Patient Safety Committee.

Infection Control > Process

Recommendations

2.6.19 Assess services provided by the off-site facilities. Determine infection control needs of staff/patients. Determine if practices are standardized and consistent across the institution.

2.6.20 Conduct daily surveillance rounds to identify and follow through on the elimination of inappropriate infection control practices.

2.6.21 Perform annual uniform competency assessment of all employees performing sterilization or high-level disinfection.

2.6.22 Develop consistent policies outlining the procedure for the monitoring of all sterilizers, including those located in Pathology and Environmental Services.

2.6.22 KDMC's TB Plan needs to be reviewed and revised annually based on the above risk assessment.

2.6.23 Categorize blood and body fluid exposures as to type of exposure, category of exposed employee, circumstances surrounding the exposure, and actions to be taken to prevent additional employee exposures.

2..6.24 Investigate, document findings and develop an action plan for each blood and body fluid exposure exposure.

2.6.25 Develop a Sharps Safety Program and define how the institution selects products that are engineered to provide employee safety and prevent exposures.

Infection Control > Process

Performance Measures

- Healthcare associated infection rate (based upon device days)
  - Current not currently collected
  - Target TBD
- Compliance with CDC hand hygiene guidelines
  - Current not currently collected
  - Target TBD
- % surgical infection prevention program compliance - appropriate selection, timeliness of administration and discontinuation of prophylactic antibiotics. (identify 1 to 2 surgical procedures to monitor)
  - Current not currently collected
  - Target 95%
- Surgical site infection rate (risk stratified data, i.e., wound class, ASA Score, and cut time)
  - Current not currently collected
  - Target benchmark to CDC's NNIS rates
- Employee PPD conversion rates (stratified by converter's department/unit)
  - Current not currently collected
  - Target base on historical data
- Employee blood and body fluid exposures
  - Current not currently collected
  - Target base on historical data

Infection Control > Process

Responsibility

- Medical Director
- Infection Control Coordinator

Section II – General Operations/Organizational Structure

7. Budget
   - Interviews
   - Prioritized Summary of Recommendations
   - Operating
   - Capital

Budget > Interviews

- A. Gray — KDMC Chief Financial Officer
- B. Gondo — KDMC Expenditure Manager

Budget > Prioritized Summary of Recommendations

Operating		
Short Term	2.7.01	Develop a planning process to identify future strategic and operational goals
Short Term	2.7.02	Develop a five-year financial assessment and plan of operational and capital needs
Short Term	2.7.03	Develop an operating budget target driven from the five-year financial plan – not based on current year spending levels.
Short Term	2.7.04	Identify the budgetary design/policy for budget development – i.e. 'zero based', fixed volume/workload estimates, expense revenue linkages.
Short Term	2.7.05	Establish a process and timeline to develop an operating plan/budget involving administrators and department managers.
Short Term	2.7.06	Provide timely actual to budget cost center data to administrators and managers.
Short Term	2.7.07	Establish a process for monthly review of budget variances and identification of plans of correction.
Short Term	2.7.08	Establish a financial dashboard for KDMC administrators and DHS.
Short term	2.7.09	Establish positive motivational stimuli to manage the operating budget, including identification of consequences for unsatisfactory budget compliance.
Capital		
Short Term	2.7.10	Establish a capital planning committee to recommend and prioritize capital spending requests to DHS
Short Term	2.7.11	Develop a strategic planning process and related three-year capital budget.
Short Term	2.7.12	Establish criteria such as patient safety and licensure needs, return on investment thresholds and desired new technology levels to determine spending priorities.
Short Term	2.7.13	Develop a contingency allocation to fund unanticipated, emergent capital needs.

Now (Dec) Urgent (Jan -Feb) Short term (2-6 months) Intermediate (4-9 months) Long term (>9 months)

Budget > Operating

Assessment

- The operating budget is primarily driven by available funding through DHS, rather than on a true assessment of organizational planning and identification of goals and financial needs.
- The lack of a cost accounting system results in an inability to perform effective financial analysis of programs and services, payers and/or providers.
- Failure to utilize the budget process as an effective planning and management tool can hamper the hospital's ability to develop locally competitive salary, benefit and pricing structures.
- Proposed operating budgets and budget approvals are broken into two segments:
  - "Status Quo" budget – a continuation of current spending levels and volumes
  - "Critical unmet needs" – new services that are perceived to meet critical needs

Budget > Operating

Assessment

- The monthly Responsibility Summary Report (RSR) is produced through the HBOC general ledger system, which is not integrated with the budget included in the Countywide Accounting and Purchasing System (CAPS). As a result, department managers have no effective mechanism for comparing actual performance to budget, and no effective process exists to hold department managers accountable for budget variances.
- There is a plan to move general ledger reporting off of the HBOC system on July 1, 2005, and to integrate it at that time with the CAPS system.
- There is no daily financial or statistical dashboard, nor comprehensive monthly financial reporting with comparisons to industry benchmarks. As a result, there is no real dialogue among the administrative and departmental leaders regarding financial performance, comparison to industry standards and/or correction of variances.

Budget > Operating

Deficiencies

- There is an ineffective process for developing the operating budget – lacking strategic, tactical and financial needs of the hospital.
- Because of the lack of broad involvement during the budget process, administrators and department managers do not feel an “ownership” of the final approved budget.
- The lack of meaningful and timely feedback on budget variances inhibits management’s ability to hold managers accountable for budget performance.
- The use of separate general ledger and budgeting systems inhibits the ability to do meaningful budget comparisons.
- The budget process is controlled by DHS rather than by hospital administration.
- No budget estimate currently exists to cover potential operating requirements associated with this assessment report and related licensure/accreditation needs.

Budget > Operating

Recommendations

2.7.1 Develop a planning process to identify future strategic and operational goals, including programs and services, for KDMC consistent with community needs.

2.7.2 Develop a five-year financial assessment and plan of operational and capital needs. Included should be comparisons to operational and financial benchmarks from similar hospital organizations.

2.7.3 Develop an operating budget target driven from the five-year financial plan – not based on current year spending levels.

2.7.4 Identify the budgetary design/policy for budget development – i.e. 'zero based', fixed volume/workload estimates, expense revenue linkages.

2.7.5 Establish a process and timeline to develop an operating plan/budget involving administrators and department managers.

2.7.6 Provide timely actual to budget cost center data to administrators and managers.

Budget > Operating

Recommendations

2.7.7 Establish a process for monthly review of budget variances and identification of plans of correction.

2.7.8 Establish a financial dashboard for KDMC administrators and DHS.

2.7.9 Establish positive motivational stimuli to manage the operating budget, including identification of consequences for unsatisfactory budget compliance.

Responsibility

- CEO

Budget > Capital

Assessment

- There is no identifiable long term capital plan for KDMC.
- The capital equipment budget, generally covering purchased items exceeding $5,000 and leases exceeding $25,000, is broken into two segments:
  - An equipment budget that is expected to approximately equal the prior year spending level, and which currently includes about $1.2 million for equipment purchases.
  - About $2 million for leases under the LA County Capital Asset Lease program (LAC-CAL).
- A maintenance budget is also provided for major maintenance needs. In the current year, this portion of the budget was approximately $1.8 million, which has been assigned primarily to roofing repairs and HVAC system upgrades. An additional $1.4 million was appropriated for Oasis and Women's Centers.
- After the final budget amounts are approved by the County, a multidisciplinary committee including nursing, administrators and physicians is responsible for allocating approved capital equipment funds against request equipment additions/replacements.

Budget > Capital

Deficiencies

- There is no inclusive capital budget planning process tied to KDMC's strategic and operational needs..
- There are no clearly defined capital budget responsibilities and accountabilities other than the allocations committee that exists after funds have been allocated.
- No budget estimate currently exists to cover potential capital requirements associated with this assessment report and related licensure/accreditation needs.

Budget > Capital

Recommendations

2.7.10 Establish a capital planning committee to recommend and prioritize capital spending requests to DHS. Include representatives from senior management, physicians, and line directors.

2.7.11 Develop a strategic planning process and related three-year capital budget.

2.7.12 Establish criteria such as patient safety and licensure needs, return on investment thresholds and desired new technology levels to determine spending priorities.

2.7.13 Develop a contingency allocation to fund unanticipated, emergent capital needs.

Responsibility

- CEO

Section II – General Operations/Organizational Structure

7. Productivity
   - Interviews
   - Prioritized Summary of Recommendations
   - Labor Overview
   - Cost Structure
   - Productivity

Productivity > Interviews

• A. Gray	Chief Financial Officer
• M. McClure	Chief Information Officer
• B. Gondo	Expenditure Management
• M. Cheng	Information Systems
• L. Barber	Nursing Administration
• A. Wecker	DHS Finance
• L. Wun-Nagaoka	DHS Finance

Productivity > Prioritized Summary of Recommendations

Productivity		
Urgent	2.8.01	Establish a process in which the LCD for KDMC is retrieved by 20th calendar day of the following month.
Urgent	2.8.02	Identify source and process with which the agency hours are retrieved by 20th calendar day of the following month. Collaborate with DHF Finance to enhance timely submission of the invoices from all vendors.
Urgent	2.8.03	Determine each cost center's UOS as a productivity measure. The UOS selection is to be made and agreed upon by C-level management and department directors. Identify source and process to collect each of the statistics.
Urgent	2.8.04	Conduct introductory sessions for the department directors and managers to assimilate them with the concept. Communicate purpose of productivity management and benefit of utilizing the tool not as a punitive tool but as a constructive tool to help managers react/plan effective staffing.
Urgent	2.8.05	Confirm with each of the C-level management and department directors that they will be accountable for his/her department's productivity compared to the baseline.
Urgent	2.8.06	Identify a process owner for productivity measurement that will be responsible for all necessary data collection, preparation and distribution of the productivity report. Train the department personnel and manager.
Urgent	2.8.07	Determine the productivity report's distribution process, including the distribution date and route, and the follow up process.

Now (Dec) Urgent (Jan -Feb) Short term (2-6 months) Intermediate (4-9 months) Long term (>9 months)

Productivity > Labor Overview

Assessment

- Setting productivity standards and measuring compliance with the standards are important to provide quality patient care. Fostering low productivity standards will increase the use of temporary staff and overtime. Both overtime and a large proportion of temporary/agency staff can have a negative impact on quality of patient care.
- FY03/04 total salaries and wages plus benefits expense was approximately 58% of total expenses. This does not include Registry (agency) expense.
- September 2004 Paid FTEs* were approximately 2,940. Those of FY03/04 were approximately 2,853 (see table below).
- Comparing the month of September 2004 to FY03/04, Registry (agency) usage has nearly doubled.
- FY03/04 Paid FTEs per AOB was 10.37 (September 2004 data unavailable).

*Both paid FTEs and Productive FTEs include employed physicians and residents as well as registry (agency). Numbers are rounded.

*Statistics presented in this page are based on GL (General Ledger), LCD (Labor Cost Distribution), Registry Report, IR (Information Report) and FPA (Financial Performance Analysis), provided by DHS Finance and KDMC Expenditure Management departments.

	Month of Sep 04	FY03/04
Paid FTEs (including Agency)	2,940	2,853
Productive FTEs (including Agency)	2,421	2,381
Registry (Agency) FTEs	305	162
Registry % of Prod Hours	14.4%	7.3%

Productivity > Labor Overview

Assessment

- There are approximately 220 cost centers in KDMC.
- Each cost center is grouped into “Category” and “Division”.
- “Category” and “Division” collectively indicate management responsibility.
  - “Category” corresponds to C-level management.
  - “Division” corresponds to department director-level management.
- Physician cost centers for both inpatient and outpatient services are set up separately from other staff cost centers, hosting physicians, residents, physician assistants.
  - However, some non-physician job positions, such as tech/specialist and clerical administration, are also included in those physician cost centers.
- See tables on the next two pages for the cost center structure.

KDMC Cost Center Structure: Part 1

*Includes all job positions. Does not include Agency.

Category	Division	FY03-04 Productive FTEs*	# of Cost Centers
MEDICAL ADMINISTRATION	MEDICAL ADMINISTRATION	319.6	8
MEDICAL ADMINISTRATION Total		319.6	8
NURSING	NURSING	664.2	63
NURSING Total		664.2	63
FINANCE	ADMITTING	42.2	2
	EXPENDITURE MANAGEMENT	24.3	5
	FISCAL ADMINISTRATION	9.4	2
	MATERIALS MANAGEMENT	43.9	3
	REVENUE MANAGEMENT	90.0	8
	UTILIZATION MANAGEMENT	17.3	2
FINANCE Total		227.0	22
INFORMATION SERVICES	COMMUNICATIONS	11.8	1
	HEALTH INFO MANAGEMENT	70.3	2
	INFORMATION SYSTEMS	33.7	3
INFORMATION SERVICES Total		115.8	6
PERSONNEL	HUMAN RESOURCES	6.5	3
PERSONNEL Total		6.5	3
SOCIAL SERVICES	SOCIAL SERVICES	27.6	3
SOCIAL SERVICES Total		27.6	3

KDMC Cost Center Structure: Part 2

*Includes all job positions. Does not include Agency.

Category	Division	FY03-04 Productive FTEs*	# of Cost Centers
OPERATIONS	AMBULARY CARE	18.7	5
	ANESTHESIOLOGY	23.7	2
	EMERGENCY SERVICES	13.7	1
	FAMILY MEDICINE	4.6	1
	HOSPITAL ADMINISTRATION	23.0	3
	HOUSEKEEPING	101.6	3
	INTERNAL MEDICINE	53.7	11
	LAUNDRY	4.3	1
	MEDICAL LIBRARY	0.8	1
	NEUROSCIENCE	35.3	3
	OBSTETRICS AND GYNECOLOGY	29.0	3
	OCCUPATIONAL THERAPY	5.2	2
	OPTHALMOLOGY	5.2	2
	ORAL MAXILLO-FACILLA	15.0	1
	OTOLARYNGOLOGY	8.7	2
	PATHOLOGY	87.9	15
	PEDIATRICS	41.0	6
	PEDIATRICS HUB	8.2	2
	PHARMACY	46.4	4
	PHYSICAL THERAPY	14.9	1
	PLANT MANAGEMENT	101.1	5
	PSYCH HOSPITAL ADMIN	7.3	3
	PSYCH MEDICAL ADMIN	11.1	5
	PSYCH NURSING	56.1	6
	RADIOLOGY	85.3	15
	RESPIRATORY THERAPY	2.3	1
	SAFETY POLICE	0.1	1
	SURGERY	53.6	10
OPERATIONS Total		858.1	115

Productivity

Assessment

- Currently, no productivity management is in place.
  - As part of monthly FPA (Financial Performance Analysis), the hospital's total number of FTEs (employees only, not including agency) has been reported.
  - Although detailed report on FTEs ("LCD", or Labor Cost Distribution) is generated on a monthly basis, no formal distribution of the report is in place.
  - Some managers have been referring to the term "FTE" interchangeably with "headcount".
  - "Registry Report" has been issued on a monthly basis by KDMC Finance and distributed to department directors; however, the current report format is somewhat confusing (details follow in later section).
  - Although major service volume statistics, such as Average Daily Census (ADC), ED visits and discharges are reported on a monthly basis in the FPA, it is difficult to relate the volume statistics to the FTE level without productivity measures in place.
- The concept of productivity management may be brand new to many employees within the hospital, including some of the management level employees, as such concept or management tool has never been utilized.

Productivity

Assessment

- KDMC Finance/Expenditure Management acts as “local contact/local data repository” for department directors and managers.
  - Handles financial data requests from department directors and managers as intermediate.
  - Prepares “Monthly Workload Statistics Report” that reports KDMC’s high-level service volume statistics, including average daily census, number of births, ER visits and ambulatory visits.
  - Understands systems surrounding payroll, as well as service volume statistics. Also understands relationship in terms of data authority between KDMC as a local hospital and DHS Finance as a centralized finance department.
  - Does not have authority on financial or statistical data, i.e., KDMC Finance department does not “finalize” the hospital’s financial or statistical data.
- KDMC Nursing utilizes ANSOS for timecard capture, as well as agency usage record within nursing area.
- KDMC Information Services provides general IT-related support, including helping KDMC Finance retrieve financial and service volume statistics remotely from DHS database.

Productivity

Assessment

- DHS Finance owns and authorizes a variety of hospital data, including payroll, registry, and service volume statistics and has authorization in closure of monthly LCD (Labor Cost Distribution, a.k.a. payroll data).
- DHS Data and Analytics Division/DHS Information Services Branch (ISB) owns “Data Warehousing Group” that hosts collection of local hospitals’ service volume statistics.
- DHS Internal Services Department (ISD) supports “Information Report (IR)” that is a collection of local hospitals’ service volume statistics linked to patient financial data.
- Employees are paid on a monthly basis (paid on the 15th of the following month).
- Employees are required to “input” their timecard on a semi-monthly (twice a month) basis.

Productivity

Assessment

LCD, or "Labor Cost Distribution" Monthly Closure

- As of the 15th of the following month, payroll data reflects the employees' "home cost center" only (not reflecting actual work location).
- On and after the 15th of the following month, department directors and/or managers make requests to DHS Finance to reflect "deviation" adjustment, i.e., adjustment to account for difference between his/her department employees' home cost center and actual worked location.
- DHS Finance then uploads the deviation adjustment in LCD.
- All six county hospitals and additional 12 public health (non-hospital) institutions (total of 18 institutions) follow the same steps.
- After all 18 institutions' deviation adjustments are completed, DHS Finance "closes" the monthly LCD.
- LCD is not available for individual hospitals until monthly closure is completed months later.

Definition of "Productive" and "Non-Productive" Hours

- DHS Finance owns a mapping of categorization of "Earning Codes" (a.k.a. pay codes).
- Once a year, DHS Finance in conjunction with county hospitals discusses and updates the categorization of each pay code into either "productive" or "non-productive" group.

Productivity

Assessment

- All registry (agency) contracts are handled by DHS Finance.
  - Finance department of Rancho Los Amigos National Rehabilitation Center ("Rancho") is handling the invoice data compilation.
- The "Registry Report" is generated by DHS Finance and Rancho Finance, two weeks after month-end.
  - The report reflects all invoices from multiple vendors that are processed as of two weeks after month-end.
  - Some vendors are submitting the invoices <30 days following the day of service rendered, others submit later than 30 days after the service.
  - There is no standard format for the invoice submission; multiple vendors submit invoices with different formats. No electronic invoicing system in place.
  - KDMC Finance, upon receipt of the "original" registry report from DHS Finance, prepares its own "summarized" registry report, including monthly projection on the agency expense. The monthly projection has been made on the agency expenses only, not on the agency hours (The agency hours reflect the invoices that are processed at the time of the "original" registry report issuance).

Productivity

Assessment

- When KDMC Finance receives another month's registry report from DHS Finance, KDMC Finance "updates" past months' registry reports, to account for invoices processed later than the last month's registry report publication.
- The report has been compiled by vendors and by service areas (not by cost centers where the agency services were provided). It is possible to reconcile the report by cost centers that used the agency, however, DHS Finance describes it "very time-consuming and needs large amount of efforts".

- At KDMC, Nursing uses ANSOS to record the agency usage within nursing area.
  - From ANSOS, monthly agency hours are available by units in nursing area.
- KDMC Finance also prepares "Quarterly Registry Report" that reports the agency usage at the individual agency worker level.

Productivity

Assessment

UOS data source: IR, or "Information Report"

- Fed by Affinity and multiple of other independently working systems, such as Lab information system and ORSOS. Hosts all county hospitals' service volume statistics.
- Supported by DHS Finance and DHS Internal Services Department.
- Inpatient days are available by nurse stations (units), outpatient visits are available by clinic codes, and ancillary procedures are available by artificial department codes (not corresponding to hospital cost centers) defined by DHS Finance.
- KDMC Finance does not have direct connection to the IR. KDMC Finance only has "remote data retrieval access to the DHS database".
- Often times the remote connection is defective, or for variety of other unknown reasons, the data is not always retrievable.

- Due to the county's "all-inclusive" billing practice (i.e., nonexistence of itemized billing), ancillary procedure counts are not those of billed procedures, but reflects procedures/services conducted ("reported" procedures).
- All ancillary procedures are also computed into RVUs.

Productivity

Assessment

- A traditional adjustment factor is not available due to the county's "all-inclusive" billing practice, adjustment factor tends to be skewed. The hospital never used it to account for inpatient/outpatient service volume relativity.
  - For the purpose of normalizing inpatient/outpatient service volume relativity among the county hospitals, "equivalent patient days" has been used by converting number of outpatient visits into inpatient days. (The conversion ratio is approximately 1:3, currently "being reviewed for exact conversion number" by DHS Finance.)
  - Although KDMC does not endorse, OSHPD (Office of Statewide Health Planning & Development) calculates all participating hospitals' gross patient service revenue, as well as the break down of the patient service revenue into inpatient and outpatient. The traditional adjustment factor can be calculated from the gross revenue. As of 12/15/04, the available data is based on FY02/03.

Productivity

Assessment

- "Labor Cost Natural Class", a.k.a. job class, is used to categorize employees in the payroll.
- For productivity management, the following job classes are excluded due to inappropriateness of measuring those employees' productivity by "hours per unit of service" measure:
  - Physicians (including Dentists) and Physicians Assistants
  - Interns, Residents and Post-graduates
- Management positions are included in the productivity management.

NCC	NCC Name	Included / Not Included in Productivity Management
001	MANAGEMENT & SUPERVISION	Included
003	MGT/SUP-SUPV STAFF NURSE	Included
010	TECHNICIAN & SPECIALIST	Included
011	DENTAL SPECIALIST	Included
015	NURSE ANESTHETIST	Included
020	REGISTERED NURSE	Included
030	LICENSED VOCATIONAL NURSE	Included
040	AIDES & ORDERLIES	Included
050	CLERICAL & OTHER ADMIN	Included
060	ENVIRONMENTAL & FOOD SVCS	Included
070	PHYSICIANS	Not Included
080	NON-PHYS MED PRACTITIONER	Included
081	DENTISTS	Not Included
084	PHYSICIAN'S ASSISTANT	Not Included
090	OTHER SALARIES & WAGES	Included
091	DENTAL INTERNS	Not Included
092	DENTAL RESIDENTS	Not Included
093	PHYS POST GRAD 1ST YR	Not Included
094	PHYS POST GRAD 2ND-7TH YR	Not Included
097	STUDENT NURSE WORKER	Included

Productivity

Deficiencies

- The delay in LCD closure is too lengthy (for example, it took more than three months to close July and August 2004 LCD). Also, KDMC has no independency in closing the LCD.
- Inaccurate registry reports have been identified, and KDMC Finance is currently "investigating the cause".
- The process of electronically retrieving IR statistics is difficult and not timely.
- Operational issues affect accuracy of the data.
- Slowness in reacting to data requests.

Productivity

Recommendations

2.8.1 Establish a process in which the LCD for KDMC is retrieved by 20th calendar day of the following month.

2.8.2 Identify the source and process with which the agency hours are retrieved by 20th calendar day of the following month. In the meantime, collaborate with DHF Finance to enhance timely submission of the invoices from all vendors.

2.8.3 Determine each cost center's UOS as a productivity measure. The UOS selection is to be made and agreed upon by C-level management and department directors. Also identify the source and process to collect each of the statistics. For the statistics collection, utilize a centralized system as much as practically possible.

Productivity

Recommendations

2.8.4 Conduct introductory sessions for the department directors and managers to assimilate them with the concept. Communicate the purpose of the productivity management, and the benefit of utilizing the tool not as a punitive tool but as a constructive tool to help managers react/plan effective staffing. Also provide examples in what is affecting productivity and what can be done to ensure service volume statistics being accurate.

2.8.5 Confirm with each of the C-level management and department directors that they will be accountable for his/her department's productivity compared to the baseline.

2.8.6 Identify a process owner that will be responsible for all necessary data collection, preparation and distribution of the productivity report. Train the department personnel and manager.

2.8.7 Determine the productivity report's distribution process, including the distribution date and route, and the follow-up process.

Productivity

Performance Measures

KING/DREW MEDICAL CENTER Key Performance Indicators

	Month Sep04	FY03-04	Month Sep04	FY03-04	Month Sep04	FY03-04	Month Sep04	FY03-04
Hours	Paid Hours		Productive Hours		OT Hours		Registry (Agency) Hours	
	504,064	5,966,303	415,035	4,980,332	Data to be Provided	Data to be provided	52,290	339,469
Volume	OP Adjustment Factor*		ALOS		AOB		ADC	
	1.36	1.36	6.28	6.77	229.1	275.1	169.0	202.9
Volume	Patient Days (Excluding Nbs)		Discharges (Excluding Nbs)		Adjusted Patient Days		Adjusted Discharges	
	5,070	74,269	807	10,966	6,872	100,673	1,094	14,865
Ratios	Non-Productive as a % of Paid Hrs		Overtime as a % of Productive Hrs		Registry (Agency) as a % of Productive Hrs		Paid FTEs	
	19.7%	17.5%			14.4%	7.3%	2,940	2,853
Indicators	Case Mix Index*		Paid FTEs per AOB		Paid Hrs per Adj Disch		NAVIGANT CONSULTING	
	1.1	1.1	12.84	10.37	460.8	401.4		

Source / Notes:

- OP Adjustment Factor is calculated based on FY02-03OSHPD report on KDMC. KDMC does not calculate OP Adjustment Factor due to its "all-inclusive" (per diem / per visit) billing practice.
- Paid Hours, Productive Hours, and Paid FTEs include all job positions in KDMC as well as Registry (Agency) Hours.
- Case Mix Index was provided by OSHPD, reflecting FY00-01 data.
- For sectios that indicate "Data to be provided", the data is unavailable as of December 2004.
- The blank sections will have the calculated indicators once all the data elements become available.

Productivity

Responsibility

- COO
- CNO

Section II – General Operations/Organizational Structure

9. Space Planning
   - Interviews
   - Prioritized Summary of Recommendations

Space Planning – Interviews

• M. Henderson	Interim Director of Plant Management
• M. Meade	Safety Officer
• A. Kattan	Chief of Staff, DHS

Space Planning > Prioritized Summary of Recommendations

Space Planning		
Now	2.10.01	All space assignments must be approved by the Hospital COO. Initial priorities should include: outpatient pharmacy relocation, proper use of the space vacated by the Women's Center services, phlebotomy expansion and ED.
Urgent	2.10.02	Launch a newly constituted space allocation committee.
Long Term	2.10.03	Integrate space allocation to the strategic plan, i.e., form follows function and function follows need). Insure significant involvement of clinical chiefs and other major stakeholders including senior management and Drew University leadership in the development of those plans.
Long Term	2.10.04	Develop zones for inpatient, ED and Trauma, ambulatory, academic, diagnostic, support and parking services. Professional architectural and consulting services will be required.

Now (Dec) Urgent (Jan -Feb) Short term (2-6 months) Intermediate (4-9 months) Long term (>9 months)

Space Planning

Assessment

- Several inpatient units are closed and unlikely to reopen soon, and two floors of the Trauma Center are unused (one of which is being built out to house the Women's Center in May, 2005, creating more vacated space).
- There is a perception that there is inadequate space for current programs and support needs.
- A Space Committee does exist as a subcommittee of the Hospital Environment of Care Committee. It is composed largely of middle management and does not have significant medical representation. Its purpose is to consider and recommend to senior management short term space allocations. It has not and does not address long range facility planning.
- The last master facility plan was completed in 1994. A copy is unavailable.
- The facilities and space allocation at KDMC are not coordinated with the county's stated plan to, among other elements, regionalize neonatal care, suspend indefinitely the Trauma service, improve the quality and effectiveness of current services, limited pediatrics and others.

Space Planning

Deficiencies

- Facility planning and space allocation are not tied to an overall strategic plan.
- Space allocation lacks significant input from the medical staff and other stakeholders, other than championing individual program requests. There is no structural link/committee structure that provides oversight and coordination that effectively involves senior management and physicians.
- There is a lack of coordination and communication with Drew University. Since the academic chairs and the clinical chiefs are the same person in each department, this should be relatively easy to address.
- There is no effective space planning function including input from and review by administration and medical staff.

Space Planning

Recommendations

2.10.1 All space assignments must be approved by the Hospital COO. Initial priorities should include: outpatient pharmacy relocation, proper use of the space vacated by the Women's Center services, phlebotomy expansion and ED.

2.10.2 Launch a newly constituted space allocation committee.

- Including administration and medical staff
- Develop specific space and facilities timetable, budget and accountabilities, and select facility priorities for structural and/or cosmetic upgrades.
- Focus on direct patient care improvements as identified in the JCAHO surveys (such as confidentiality of counseling and long waiting lines).
- Focus should also include OR, Pharmacy and ED deficiencies not identified explicitly in the surveys.
- Space analysis must also include infrastructure (i.e., HVAC, elevators, roofing and grounds).

2.10.3 Integrate space allocation into the strategic plan (i.e., form follows function and function follows need). Insure significant involvement of clinical chiefs and other major stakeholders including senior management and Drew University leadership in the development of those plans.

2.10.4 Develop zones for inpatient, ED and Trauma, ambulatory, academic, diagnostic, support and parking services. Professional architectural and consulting services will be required.

Space Planning

Responsibility

- COO

Section II – General Operations / Organizational Structure

10. Environment of Care
    - Interviews
    - Prioritized Summary of Recommendations
    - Overview
    - Patient Care Units
    - Psychiatric Unit

Environment of Care > Interviews

M. Meade	Environmental Safety Officer
N. Datta, MD	Acting Chair, Surgery
N. Smith	Clinical Manager, OR
M. Henderson	Interim Director, Plant Management
A. Smith	Psych Manager
O. O'Rourke	Nursing Director

Environment of Care > Prioritized Summary of Recommendations

Overview		
Short Term	2.10.01	Develop a format for all Environment of Care programs to follow in assessing their Annual Effectiveness including the Performance Measure Indicator summary.
Urgent	2.10.02	Establish a format for reporting that includes all of the JCAHO Elements of Performance (EPs) and Performance Measures and criteria for effectiveness.
Urgent	2.10.03	Complete an annual evaluation and review for approval with the Safety Committee.
Urgent	2.10.04	Mandate Safety Committee attendance (report attendance from every meeting to Leadership for follow-up).
Urgent	2.10.05	Refine Safety Committee agenda to reflect timely data and information required to make decisions. Establish monitors to reflect trends and patterns that require improvement.
Urgent	2.10.06	Adopt established/recognized monitors that demonstrate continued compliance within each Environment of Care program along with cooperation of other organizational entities in providing data for measurement.
Now	2.10.07	Conduct consistent Daily Safety rounds or - based on improved outcome, the frequency of Safety rounds needs to be adjusted and communicated to the Authorities having Jurisdiction to which the daily rounds were committed.
Now	2.10.08	Complete a weekly overview of the percent of scheduled inspections done along with any trends and patterns.
Urgent	2.10.09	Fill the vacant Safety Officer position immediately and provide clerical/statistical assistance to the safety office (perhaps a shared position with Patient Safety or Performance Improvement).
Urgent	2.10.10	Circulate a memo to the effect that all current policies, procedures and guidelines are to be considered approved during the ongoing review and revision process.
Short term	2.10.11	Review all documents requiring authorization signatures; such as the appointment of the Safety Officer, Authorization for Intervention in an Emergency, appointment of Security responsibility, and others.
Urgent	2.10.12	Conduct an annual review of the Environment of Care program.
Urgent	2.10.13	Inform all entities comprising KDMC of Recall and Hazard Warning Policy.
Short term	2.10.14	Maintain a Recalls and Hazard Warnings log in Materials Management.
Short term	2.10.15	Communicate any Recall or Hazard Warning found unreported per policy to Leadership, Risk Management, and the Safety office.

Now (Dec) Urgent (Jan-Feb) Short term (2-6 months) Intermediate (4-9 months) Long term (>9 months)

Environment of Care > Prioritized Summary of Recommendations

Overview		
Short term	2.10.16	Report at least quarterly, measures with a denominator that allows some benchmarking and trending to occur (example: injuries per 1,000 employee hours; lost workdays per 10,000 employee hours).
Short term	2.10.17	Participate in a collaborative effort, within County system, that would benefit the rotation of County Police and better prepare them to respond to Mental Health patients and other high risk scenarios.
Now	2.10.18	Implement just-in-time orientation for County Police that have not worked at KDMC regularly within the last month.
Urgent	2.10.19	Conduct and complete a comprehensive risk assessment of all Mental Health treatment areas, with the intent on reducing the hazards that pose risks to the patients and staff.
Short term	2.10.20	Establish specific guidelines for the design improvement of the Mental Health treatment environment based on code, standard, regulation, and best practice.
Urgent	2.10.21	Complete an updated SOC for each Healthcare Occupancy per JCAHO requirements based on the 2000 NFPA 101 Life Safety Code per JCAHO and CMS.
Urgent	2.10.22	Conduct/complete comprehensive risk assessment of all Surgery areas to reduce hazards to patients and staff.
Now	2.10.23	Conduct ongoing Environmental tours by consultants and organizational staff.
Short term	2.10.24	Extend the same communication/notification system to “MED Alert” Incident Commanders that exists for other manager/supervisor groups.
Now	2.10.25	Execute routine monthly “tests” and emergency management drills and implementation critiques.
Urgent	2.10.26	Complete a thorough infant abduction assessment by an infant abduction expert.
Now	2.10.27	Maintain the committed frequency of Fire Safety rounds.
Urgent	2.10.28	Develop a matrix that allows the scheduling of Fire drills to include all shifts worked by staff.
Urgent	2.10.29	Follow through on the proposed contract to test all Fire and Smoke Dampers.
Urgent	2.10.30	Reorganize Safety, Patient Safety, and Performance Improvement activities.
Urgent	2.10.31	Involve Medical Equipment manager with all ME contract activities to assure a consistent program/compliance.
Short term	2.10.32	Identify and report departments / services in violation of the incoming Medical Equipment policy.
Now	2.10.33	Provide coaching / support to the Environmental Safety Officer and Interim Director, Plant Management
Now	2.10.34	Track the compliance of the identified EC deficiencies

Environment of Care

Assessment

- The Annual Evaluation for Effectiveness of the Environment of Care Program for 2003 reviewed in the Safety Minutes does not appear consistent in format nor does it include Performance Measure Indicator Annual Summary.
- Documentation in Safety Committee minutes is sparse based on deferred and tabled reports due to absenteeism of members and lack of data / information from programs.
- Daily Safety rounds are not being consistently met.
- The Safety office currently is providing almost all of the Environment of Care compliance effort It is understaffed by one vacant position and requires additional clerical / statistical support. If the Environment of Care program is expected to perform effectively and efficiently, there needs to be the necessary staffing support to sustain that effort.
- The Leadership has not approved the current Environment of Care as well as other crucial documents.
- The Recall and Hazard Warning Policy for products and equipment has recently been rewritten but is not yet followed by all participants within the organization. The coordination of services with separate purchasing abilities (Pharmacy) and other contract services (Dietary) make for a somewhat fragmented effort at present.

Environment of Care

Assessment

- The lone Incident/Accident report for 2004 was submitted to the Safety office in November and contained raw data only (injury breakdown by organization for all county healthcare services).
- The County Police staff serving at King / Drew Medical Center are frequently drawn from other County healthcare facilities including the supervising officers. However, there is little if any standardization between healthcare facilities within the County system, which puts the officers, employees, patients, and community served at some risk.
- A tour of the Mental Health units indicates that there are potentially serious environmental safety issues in patient rooms, even in the remodeled rooms.
- A review of the Statement of Conditions (SOC) and brief tours of the patient care buildings indicates that the current SOC is not accurate
- A tour of the Surgery Suites indicates that there are potentially serious environmental safety issues in storage rooms, and even in the surgery suites.
- Incident Commanders are not provided the same communication / notification system that other programs within the hospital have.

Environment of Care

Assessment

- Daily Fire Safety rounds are not being consistently met.
- It is not known if the current Fire drill schedule includes all shifts worked by staff.
- The damper testing has not yet been accomplished although it is approved and will be scheduled by 2005.
- Not all Medical Equipment is inspected “prior to use” as it does not follow the prescribed protocol for incoming Medical Equipment. This is a department / service violation of policy issue.
- The integration of Safety and Patient Safety is fragmented at best. The ongoing reorganization and rotating door of Leadership seems to have further complicated this issue.
- There are many contract Medical Equipment maintainers (ICU Monitors, Anesthesia, Respiratory, Radiology, and Dialysis) that should be better integrated into the Medical equipment program.

Environment of Care

Deficiencies

- Insufficient resources to the environment of care compliance.
- Ineffective environment of care program.
- Ineffective governance by the Safety Committee.

Recommendations

2.10.1 Develop a format for all Environment of Care programs to follow in assessing their Annual Effectiveness including the Performance Measure Indicator summary.

2.10.2 Establish a format for reporting that includes all of the JCAHO Elements of Performance (EPs), Measures of Success (MOS) and Performance Measures and criteria for effectiveness.

2.10.3 Complete an annual evaluation and review for approval with the Safety Committee.

2.10.4 Mandate Safety Committee attendance (report of attendance from every meeting sent to Leadership for any indicated follow-up).

- Appoint secondary to the primary Safety Committee member that would represent the primary person in their absence.

Environment of Care

Recommendations

2.10.5 Refine the Safety Committee agenda to reflect timely data and information required to make decisions. Establish monitors to reflect trends and patterns that require improvement.

2.10.6 Adopt established/recognized monitors that demonstrate continued compliance within each Environment of Care program along with cooperation of other organizational entities in providing data for measurement (i.e., Human Resources w/ hours worked per dept/service per month).

2.10.7 Conduct consistent Daily Safety rounds the frequency of Safety rounds should be adjusted and communicated to the authorities having jurisdiction to which the daily rounds were committed.

2.10.8 Complete a weekly overview of the percent of scheduled inspections done along with any trends and patterns.

2.10.9 Fill the vacant Safety Officer position immediately and provide clerical/statistical assistance to the safety office (perhaps a shared position with Patient Safety or Performance Improvement).

Environment of Care

Recommendations

2.10.10 Circulate a memo to the effect that all current policies, procedures and guidelines are to be considered approved during the ongoing review and revision process.

2.10.11 Review all documents requiring authorization signatures; such as the appointment of the Safety Officer, Authorization for Intervention in an Emergency, appointment of Security responsibility, and others.

2.10.12 Conduct an annual review of the Environment of Care program.

2.10.13 Inform all entities comprising the King / Drew Medical Center, and the acknowledge, of the Recall and Hazard Warning Policy.

2.10.14 Maintain a Recalls and Hazard Warnings log in Materials Management.

2.10.15 Communicate any Recall or Hazard Warning found unreported per policy to Leadership, Risk Management, and the Safety office.

2.10.16 Report at least quarterly, measures with a denominator that allows some benchmarking and trending to occur (example: injuries per 1,000 employee hours; lost workdays per 10,000 employee hours).

2.10.17 Participate in a collaborative effort, within the County system, to achieve a level of standardization that would benefit the rotation of County Police and better prepare them to respond to Mental Health patients and other potential high risk scenarios.

Environment of Care

Recommendations

2.10.18 Implement just-in-time orientation for County Police that have not worked at KDMC regularly within the last month.

2.10.19 Conduct and complete a comprehensive risk assessment of all Mental Health treatment areas, with the intent on reducing the hazards that pose risks to the patients and staff.

2.10.20 Establish specific guidelines for the design improvement of the Mental Health treatment environment based on code, standard, regulation, and best practice.

2.10.21 Complete an updated SOC for each Healthcare Occupancy per JCAHO requirements based on the 2000 NFPA 101 Life Safety Code© per JCAHO and CMS.

2.10.22 Conduct and complete a comprehensive risk assessment of all Surgery areas with the intent on reducing the hazards that pose risks to the patients and staff.

2.10.23 Conduct ongoing Environmental tours by consultants and organizational staff.

2.10.24 Extend the same communication/notification system to “MED Alert” Incident Commanders that exists for other manager/supervisor groups.

Environment of Care

Recommendations

2.10.25 Execute routine monthly “tests” and emergency management drills and implementation critiques.

2.10.26 Complete a thorough infant abduction assessment by an infant abduction expert.

2.10.27 Maintain the committed frequency of Fire Safety rounds.

- The frequency of the rounds need to be adjusted once the compliance with Fire Safety has been achieved and then the adjustment be communicated to the Authorities Having Jurisdiction to which the daily rounds were committed.

2.10.28 Develop a matrix that allows the scheduling of Fire drills to include all shifts worked by staff.

2.10.29 Follow through on the proposed contract to test all Fire and Smoke Dampers.

2.10.30 Reorganize Safety, Patient Safety, and Performance Improvement activities.

2.10.31 Involve the Medical Equipment manager with all contract activities regarding Medical Equipment to assure a consistent program and regulatory compliance.

2.10.32 Identify and report departments / services in violation of the incoming Medical Equipment policy.

Recommendations

2.10.33 Provide coaching / support to the Environmental Safety Officer and Interim Director, Plant Management in the following areas:

- Completion of Statement of Conditions.
- Continuous Compliance Assessment of Statement of Conditions. The assessment will include a periodic:
  - Quarterly review of the Building Maintenance Program or assistance in developing a program, as it will be critical to maintaining the current SOC.
  - Quarterly review of Safety Committee minutes for meeting the current SOC documentation.
  - Quarterly review the status of the SOC regarding completion of the Part 4, Plan for Improvement (PFI).
  - A semi-annual focus inspection of the physical changes to the building in the last year.
  - A semi-annual random check of the Life Safety compliance of the building, checking above ceilings, exits, and fire/smoke doors will be conducted.
  - A semi-annual update of the SOC Part 4 will be provided as part of the report.

2.10.34 Track compliance of the identified EC deficiencies.

Environment of Care

Performance Measures

Safety

- Total patient slips and falls per 1000 patient days
  - Current not currently measured
  - Target TBD
- Number of self-injury per 1000 psychiatric patient days (Adolescent / Adult to be separated)
  - Current not currently measured
  - Target TBD
- Number of physical assault per 1000 psychiatric patient days(Adolescent / Adult to be separated)
  - Current not currently measured
  - Target TBD
- Employee injuries per 100 actual FTEs
  - Current not currently measured
  - Target TBD
- Employee Workers' Compensation Claims per 100 actual FTEs
  - Current not currently measured
  - Target TBD

Environment of Care

Performance Measures

Security

- Number of security actual FTEs per 100,000 sq ft (including parking)
  - Current not currently measured
  - Target TBD
- Number of assaults against patients per 100,000 sq ft (buildings & parking)
  - Current not currently measured
  - Target TBD
- Number of assaults against employees per 100,000 sq ft (buildings & parking)
  - Current not currently measured
  - Target TBD
- Number of assaults against visitors per 100,000 sq ft (buildings & parking)
  - Current not currently measured
  - Target TBD
- Number of of robberies per 100,000 sq ft (buildings & parking)
  - Current not currently measured
  - Target TBD

Environment of Care

Performance Measures

Security

- Number of thefts per 100,000 sq ft (buildings & parking)
  - Current not currently measured
  - Target TBD
- Number of property damage/vandalism per 100,000 sq ft (buildings & parking)
  - Current not currently measured
  - Target TBD
- Number of auto break-ins per 100,000 sq ft parking
  - Current not currently measured
  - Target TBD
- Number of auto thefts per 100,000 sq ft parking
  - Current not currently measured
  - Target TBD

Environment of Care

Performance Measures

Hazmat

- Number of skin/mucous membrane exposures per 100 actual FTEs
  - Current not currently measured
  - Target TBD
- Number of solid needle / sharps injuries per 100 actual FTEs
  - Current not currently measured
  - Target TBD
- Number of hollow needle injuries per 100 actual FTEs
  - Current not currently measured
  - Target TBD
- Number of chemical spills
  - Current not currently measured
  - Target TBD

Environment of Care

Performance Measures

Emergency Management

- Number of Emergency Management drills
  - Current not currently measured
  - Target TBD
- Number of Emergency patients requiring decontamination facilities
  - Current not currently measured
  - Target TBD
- Number of employees that received smallpox immunization since 2002 (exclude military)
  - Current not currently measured
  - Target TBD

Environment of Care

Performance Measures

Fire Safety

- Number of fires per 1,000,000 sq ft (occupied)
  - Current not currently measured
  - Target TBD
- Failure rate (percentage of total count)
  - Supervisory signal devices
  - Valve tamper & flow switches
  - Duct detectors, smoke detectors, heat detectors, pull stations, electromechanical releasing devices
  - Occupant notification devices (audible & visual)
  - Fire / smoke dampers
  - Automatic smoke detection shutdown for air handling
    - Current not currently measured
    - Target TBD

Environment of Care

Performance Measures

Medical Equipment

- Percentage of Medical Equipment inventory with failure
  - Current not currently measured
  - Target TBD
- Percentage of Medical Equipment inventory w/ failed test/inspection
  - Current not currently measured
  - Target TBD
- Percentage PM completion rate
  - Current not currently measured
  - Target TBD
- Percentage of Medical Equipment inventory w/ could not find
  - Current not currently measured
  - Target TBD
- Percentage of Medical Equipment inventory w/ user error
  - Current not currently measured
  - Target TBD

Environment of Care

Performance Measures

Medical Equipment

- Number of pumps without free flow protection
  - Current not currently measured
  - Target TBD
- Number of incidents where clinical staff did not hear or respond to timely to Medical Equipment Alarm
  - Current not currently measured
  - Target TBD
- Number of pieces of Medical Equipment per actual In-house Bio-med employee hours worked
  - Current not currently measured
  - Target TBD
- Number of pieces of Medical Equipment found w/o incoming inspection
  - Current not currently measured
  - Target TBD

Environment of Care

Performance Measures

Utility Systems

- Percentage PM completion rate
  - Current not currently measured
  - Target TBD
- Emergency Electrical generator failure per generator
  - Current not currently measured
  - Target TBD
- Actual FTEs per 1000,000 sq ft buildings
  - Current not currently measured
  - Target TBD

Environment of Care

Responsibility

- COO

Section II – General Operations / Organizational Structure

11. Facilities Management
    - Interviews
    - Prioritized Summary of Recommendations
    - Clinical Engineering
    - Plant Engineering
    - Environmental Services

Facilities Management > Interviews

- M. Henderson — Interim Director
- P. Valenzuela — Lead Administrator
- R. Ward, PhD — Director, Biomedical Engineering
- F. Ponder — Director, Environmental Services

Facilities Management > Prioritized Summary of Recommendations

Clinical Engineering		
Now	2.11.01	Identify responsibility for maintaining and cleaning medical equipment.
Urgent	2.11.02	Develop an annual plan for inservice education for nurses and others regarding monitoring equipment.
Short term	2.11.03	Develop productivity standards and hold staff individually responsible for performance, particularly with regard to preventive maintenance
Plant Engineering		
Short term	2.11.04	Develop a comprehensive preventive maintenance plan in plant management.
Short term	2.11.05	Develop a comprehensive plan for routinely refurbishing the facility. Priority given to public and patient areas.
Short term	2.11.06	Develop productivity standards and staff held individually accountable for performance, particularly with regard to PM completion.
Now	2.11.07	Conduct a “make or buy” evaluation should be done for future construction and renovation projects.
Environmental Services		
Short term	2.11.08	Productivity standards should be developed, and each evaluation should include performance against those standards.
Short term	2.11.09	Evaluate outsourcing management and the operations of Environmental Services.

Now (Dec) Urgent (Jan-Feb) Short term (2-6 months) Intermediate (4-9 months) Long term (>9 months)

Facilities Management > Clinical Engineering

Assessment

- Staff consists of 10 engineers and technicians for approximately 6,000 pieces of equipment. Repair and maintenance for major radiologic equipment is contracted out.
- Leadership is perceived as very capable and knowledgeable, relating well with customers on a limited basis.
- Quality of the repair and preventive maintenance is seen as adequate.
- Inservice and training on the use of the equipment is not consistently programmed.
- Preventive maintenance schedules exist but are not monitored for completion.
- Equipment logs and PM schedules are not integrated.

Facilities Management > Clinical Engineering

Deficiencies

- Responsibility for maintaining, repairing and cleaning is split among Biomedical Engineering, Environmental Services and selected contractors.
- Nurses and other clinicians do not demonstrate consistent proficiency in the use of monitoring equipment.
- Preventive maintenance is not consistently monitored and accomplished.

Recommendations

2.11.1 Identify responsibility for maintaining and cleaning medical equipment.

2.11.2 Develop an annual plan for inservice education for nurses and others regarding monitoring equipment.

2.11.3 Develop productivity standards and hold staff individually responsible for performance, particularly with regard to preventive maintenance.

Facilities Management > Clinical Engineering

Performance Measures

- See Environment of Care Performance Measures
- Productivity: Worked hours per adjusted patient day
  - Current not currently collected
  - Target .12
- Total repair and maintenance cost per occupied bed
  - Current not currently collected
  - Target TBD

Responsibility

- COO
- Director, Biomed

Facilities Management > Plant Engineering

Assessment

- Staff consists of 103 items, including all trades, not including biomedical engineering for a facility slightly in excess of 1.5m square feet.
- Leadership is provided on an interim basis by three managers on loan from DHS. The interim director is perceived as capable, knowledgeable and works well with peers.
- The functions of the department include preventive maintenance and repair. Virtually all significant construction and renovation is outsourced.
- Preventive maintenance and a sustained investment in the facility and its aesthetics have been lacking. The priority has been repair, rather than maintenance. Selected PM schedules exist but have not been adhered to.
- The scope and quality of the work done is good. All technical capabilities to do more significant construction and renovation exist.
- Interaction with customers, such as Nursing directors, is perceived as improving with new management.

Facilities Management > Plant Engineering

Deficiencies

- Preventive maintenance plans exist but are not routinely monitored or accomplished.
- There is not an ongoing schedule of refurbishment.
- Virtually all significant construction and renovation is outsourced, despite significant inhouse capability.
- Staff priority has been repair, then maintenance, then renovation.

Recommendations

2.11.4 Develop a comprehensive preventive maintenance plan in plant management.
  – The plan should include at least HVAC systems, power plant, roofing, elevators, lighting and ceiling repair.

2.11.5 Develop a comprehensive plan for routinely refurbishing the facility. Priority given to public and patient areas.

2.11.6 Develop productivity standards and staff held individually accountable for performance, particularly with regard to PM completion.

2.11.7 Conduct a “make or buy” evaluation should be done for future construction and renovation projects.

Facilities Management > Plant Engineering

Performance Measures

- See Environment of Care Performance Measures
- Productivity: Worked hours per 1000 square feet maintained
  - Current not currently collected
  - Target 3.5
- Number of unresolved work orders
  - Current not currently collected
  - Target TBD

Responsibility

- COO
- Director of Plant Management

Facilities Management > Environmental Services

Assessment

- Staff consists of a total of 137 FTEs including 6 in the laundry.
- Leadership is seen as committed to improvement, but ineffective in changing the perceptions of customers that the place is dirty.
- There is a general perception that there is too much clutter, litter and dust. Limited satisfaction studies and personal observation support that perception.
- Off-shift support and supervision is seen as particularly weak.
- EVS includes housekeeping and laundry service for the entire campus.

Facilities Management > Environmental Services

Deficiencies

- The level of cleanliness is not measured, trended and analyzed. What evidence exists indicates an unsatisfactory level.
- Off shift supervision and performance is consistently reported to be unsatisfactory with regard to availability and responsiveness.

Recommendations

11.1.8 Productivity standards should be developed, and each evaluation should include performance against those standards.

11.1.9 Evaluate outsourcing management and the operations of Environmental Services.

Facilities Management > Environmental Services

Performance Measures

- Productivity: Worked Hours per 1000 Square Feet Maintained
  - Current not currently collected
  - Target 1.68
- Quality scores from objective sampled review of cleanliness
  - Current not currently collected
  - Target TBD
- Percentage of “routine” rooms responded to within 30 minutes
  - Current not currently collected
  - Target 90%
- Percentage of “STAT” rooms responded to within 15 minutes
  - Current not currently collected
  - Target 95%
- Percentage of rooms called “STAT”
  - Current not currently collected
  - Target 20%

Responsibility

- COO
- Director of Environmental Services

Section II – General Operations / Organizational Structure

12. Materials Management
    - Interviews
    - Prioritized Summary of Recommendations

Materials Management > Interviews

• A. Gray	Chief Financial Officer
• E. Bolden	Materials Management

Materials Management > Prioritized Summary of Recommendations

Materials Management		
Short term	2.12.01	Implement electronic requisitioning process.
Short term	2.12.02	Educate end users on the requisitioning process.
Short term	2.12.03	Evaluate the role and the reporting of the Value Analysis Facilitator.
Short term	2.12.04	Consolidate the invoice processing/accounts payable unit in Materials Management with Expenditure Management.
Short term	2.12.05	Establish the supply chain operations infrastructure with clearly defined lines of accountability and authority.
Short term	2.12.06	Complete an inventory assessment in the cath lab and operating room.
Short term	2.12.07	Work to develop consignment relationships with vendors particularly for high-priced physician preference items.
Short term	2.12.08	Formalize and enhance supply chain performance measurement reporting.
	2.12.09	Distribute performance reports to key executives and department leadership.
Urgent	2.12.10	Conduct detailed analysis of Novation contracts with respect to KDMC purchases to identify optimization opportunities where reasonable and appropriate.
Short term	2.12.11	Increase communication with physicians, with support from hospital leadership, to increase standardization of clinical product selection.
Short term	2.12.12	Establish Value Analysis Team that encompasses all clinical and non-clinical areas.
Short term	2.12.13	Develop and adopt a product acquisition and management approach to managing entry of new products and evaluating existing products/services for standardization/utilization opportunities

Now (Dec) Urgent (Jan-Feb) Short term (2-6 months) Intermediate (4-9 months) Long term (>9 months)

Materials Management

Assessment

- Materials Management at KDMC reports to the CFO.
- Local functions include:
  - Warehouse Management
  - Procurement
  - Central Services
  - Forms Design
  - Invoice Processing
  - Fixed Asset/Processing
- Paid FTEs 59, budgeted at 82.3.
  - 10 managers/supervisors
  - 41 technicians/specialists
  - 6 clerical and other
  - 2 other
- Pharmacy purchases are coordinated through the LAC and USC Medical Center. The KDMC Pharmacy manages its own inventory and utilizes HMMS in a manner similar to Materials Management.
- Materials management is a DHS-wide process. Other DHS hospitals use similar processes.
- The group purchasing organization is UHC/Novation.
- There is a Value Analysis Facilitator who's role is to identify and evaluate the use of new products and improved efficiencies. This person reports to the COO.

Materials Management

Assessment

Procurement

- All purchases go through a bid process or require substantial justification.
- ISD Purchasing has delegated pre-approved authority to KDMC thresholds:
  - $15,000 with an appropriate quote, justification and vendor contract.
  - Minority or woman's vendors - $10K post to their internet.
  - $5,000 sole source.
  - Internal $1,500 requires secondary administrative approval within the facility.
- Requisitions go first to Materials Management then Purchasing (County) who has final clearance. This varies depending on cost, product or service being requested, and delegated authority.
- There are 1,100 to 1,300 requisitions per month that are all hard copy and processed manually.
- Items ordered by departments are often made without use of specifications, catalogues or vendor references.
- There is a plan to begin an on-line requisitioning process that should be functioning in February 2005 (currently up in two of the county hospitals). It is a PC based home grown system that does not interface with ISD.
- The requisitioning process has many steps and a long purchasing cycle.

Materials Management

Assessment

Equipment Management

- Maintenance contracts are centrally coordinated but managed at the department level.
- A formal process for the approval of equipment exists but is not linked with scheduled retirement and replenishment. Group oversight exists but does not fully asses each departments true need. A cost benefit is not evaluated at the time each request is submitted. Most equipment gets approved subject primarily to the discretion of each department.
- No comprehensive equipment inventory exists that closely tracks movement of equipment throughout the hospital.
- There are problems tracking minor equipment and items that move frequently between units and service departments.
- There is no system for tracking useful life for planned replenishment.
- There is no preventative maintenance program in place.
  - No bed rotation plan.
- There is no process for insuring cost effective maintenance contracts are in place.

Inventory

- Warehouse inventory is automated with pre-authorized stock replenishment activities.
- The cath lab and operating room maintain their own inventory.
  - There is an antiquated inventory system - all manual.
  - There is no use of consignment.
  - Current levels and turns are not known.

Materials Management

Assessment

Expense Management

- Responsibility Summary Report (PSR's) comes out monthly, 30 to 40 days after the period, with YTD actual service/supply expenditure. Reports are formatted to compare actual to budget.
- There is minimal to no focus or effort on management of expenses at the department level.
- There is no accountability at the department level to manage expenses.
- Some minimal supply benchmarks are reported at executive meetings.

Invoice Processing

- Interfaces with county-wide payment system.
- Expenditure management processes Board approved contract invoices for payment but invoice payments for supplies are handled by Materials Management.

Materials Management

Deficiencies

- Inadequate plant asset system to track equipment inventory.
- Contract payment processing and purchase order processing is not integrated.
- Requisitioning is currently all done manually.
- Inventories in high cost areas are not managed by Materials Management.
- There is a lack of a coordinated expense management process.

Recommendations

2.12.1 Implement electronic requisitioning process.

2.12.2 Educate end users on the requisitioning process.

2.12.3 Evaluate the role and the reporting of the Value Analysis Facilitator.

2.12.4 Consolidate the invoice processing/accounts payable unit in Materials Management with Expenditure Management.

2.12.5 Establish the supply chain operations infrastructure with clearly defined lines of accountability and authority.

2.12.6 Complete an inventory assessment in the cath lab and operating room.

Materials Management

Recommendations

2.12.7 Work to develop consignment relationships with vendors particularly for high priced physician preference items.

2.12.8 Formalize and enhance supply chain performance measurement reporting.

2.12.9 Distribute performance reports to key executives and department leadership.

2.12.10 Conduct detailed analysis of Novation contracts with respect to KDMC purchases to identify optimization opportunities where reasonable and appropriate.

2.12.11 Increase communication with physicians, with support from hospital leadership, to increase standardization of clinical product selection.

2.12.12 Establish a Value Analysis Team that encompasses all clinical and non-clinical areas.

2.12.12 Develop and adopt a product acquisition and management approach to managing entry of new products and evaluating existing products/services for standardization/utilization opportunities

- Include major categories of products/services with key representatives.

Materials Management

Performance Measures

- Percentage of electronic requisitions
  - Current not available
  - Target 70%
- Percentage of departmental orders reviewed and assigned to procurement within 24 hours of receipt
  - Current not currently provided
  - Target TBD
- Percentage of vendor invoices processed to HMMS within 24 hours of receipt
  - Current not provide
  - Target TBD
- Percentage of warehouse product deliveries to user departments within 2 days of receipt from the vendor
  - Current not provided
  - Target TBD
- Reported occurrences of incomplete surgical trays
  - Current not provided
  - Target YBD
- Percentage of orders placed by procurement staff with vendors within 5 business days from receipt
  - Current not provided
  - Target TBD

Materials Management

Performance Measures

- Time from requisition of order to receipt of product (end user)
  - Current not currently collected
  - Target TBD
- Inventory turns – warehouse
  - Current 11.5
  - Target 15 - 20
- Inventory turns – central supply
  - Current 15
  - Target 15 - 20
- Supply, drugs and consumables (SDC) as % operating expense
  - Current not calculated
  - Target 18 – 17.5%
- SDC dollars per adjusted patient day
  - Current current data not available
  - Target TBD
- SDC dollars per adjusted discharge
  - Current current data not available
  - Target TBD
- SDC as % of net revenue
  - Current current data not available
  - Target TBD

Materials Management

Responsibility

- CFO
- Director of Materials Management

Section II – General Operations / Organizational Structure

13. Contracted Services
    - Interviews
    - Prioritized Summary of Recommendations
    - Respiratory Care
    - Dietary Services
    - Security

Contracted Services > Interviews

• Captain C. Tyus	LA County Police
• Chief M. York	LA County Police
• V. Turner	Health Services Bureau Chief
• N. Cortes	Director, Respiratory Therapy
• T. Gutierrez	Director, Dietary Services
• P. Price	Chief Nursing Officer
• M. Meade	Chief Safety Officer
• O. O'Rourke	Interim Nursing Director

Contracted Services > Prioritized Summary of Recommendations

Respiratory Care		
Now	2.13.01	Hold IHS accountable for lack of performance against contract terms.
Now	2.13.02	Insure and document that all contractors participate in orientation.
Short term	2.13.03	Conduct a monthly audit of compliance with contracted performance measures.
Short term	2.13.04	Hold the contractor accountable for development of a plan for correction.
Short term	2.13.05	Conduct a review of the contract, its financial and performance terms and its continuation.
Urgent	2.13.06	Insure the appropriate use and control of respiratory medications.
Sort term	2.13.07	Develop a plan for the regular replacement and upgrading of equipment.
Dietary Services		
Short term	2.13.08	Review of the kitchen's facility needs should be undertaken. Specific timetables, costs and accountabilities should be developed.
Short term	2.13.09	Conduct a review of the cafeteria's aesthetics and traffic flow.
Urgent	2.13.10	Ensure inservice classes are provided on therapeutic diets, proper food storage procedures and sanitation of equipment..
Urgent	2.13.11	Institute a daily log to ensure that appropriate temperatures are being maintained and communicate the results go to the Ancillary IOP and then on to the Hospital IOP.
Urgent	2.13.12	Include content on fluid restriction and portion size in the dietary orientation. Ensure Registered Dieticians monitoring fluid restrictions.
Urgent	2.13.13	Conduct random reviews of cardexes and compare them to Affinity for issues and identify plans for resolution.
Urgent	2.13.14	Establish a prioritized matrix to provide nursing information on the routine consults by dietary based on diagnosis.
Urgent	2.13.15	Ensure all patients are receiving a nutritional assessment by a Registered Dietician.

Contracted Services > Prioritized Summary of Recommendations

Security		
Now	2.13.16	Review and update policies regarding use of taser, reexamine them for their effectiveness and regulatory compliance.
Now	2.13.17	Provide intensive inservicing regarding these new policies.
Now	2.13.18	Insure compliance with these new policies.
Urgent	2.13.19	Include all new policies in standard orientation to KDMC and incorporate into inservice required of each officer rotated onto the campus.
Now	2.13.20	Execute mock codes on all three shifts across all services and identify gaps in response and resolve.
Short term	2.13.21	Develop a succession plan for leadership.

Now (Dec) Urgent (Jan-Feb) Short term (2-6 months) Intermediate (4-9 months) Long term (>9 months)

Contracted Services > Respiratory Care

Assessment

- Respiratory Care is contracted out to IHS Symphony. The contract is for KDMC and expires in 2006.
- Administrative responsibility lies with the Lead Administrator for Clinical Services.
- Respiratory has been cited for non-compliance in our regulatory review and must insure that all contracted employees have documented participation in orientation. Currently, fewer than half the contracted employees have documented participation.
- Detailed Performance Requirements exist in the contract identifying 36 required services.
  - Each service has an indicator, performance standard, maximum allowable variance and method of monitoring.
- Recent sample audit of compliance (done by Nursing Service) with contract terms relating to documentation and technical performance shows substantial lack of compliance.
  - With regard to required documentation, compliance ranged from 31 to 100%.
  - With regard to technical performance, compliance ranged from 0 to 71%. The threshold in the contract is 95%.
- A plan of correction is in development.

Contracted Services > Respiratory Care

Assessment

- Service is perceived to be average by a sampling of physicians and nurses. Number of staff is deemed to be adequate. The contract specifies fees that vary with volume, but does not specify that staff will vary proportionately, thereby creating an incentive for increasing volume without increasing staff.
- However, a significant component of contractors are registry staff, compromising continuity.
- Fewer than half the current contractors have documented participation in orientation.
- Respiratory Therapists do not appear to be aggressive about treatment modalities or involvement with care planning. There are not regular forums for joint nursing/RT issues to be addressed.
- Much of the equipment is not state-of-the–art. Specifically, one blood gas analyzer and many ventilators are two generations old technologically.

Contracted Services > Respiratory Care

Deficiencies

- The contractor has not complied with the performance requirements of the contract.
- Management has not held the contractor to the terms.
- Much of the equipment is technologically out of date, and there is not an ongoing schedule for replacement and upgrading.

Recommendations

2.13.1 Hold HIS Symphony accountable for lack of performance against contract terms.

2.13.2 Insure and document that all contractors participate in orientation.

2.13.3 Conduct a monthly audit of compliance with contracted performance measures.

2.13.4 Hold the contractor accountable for development of a plan for correction.

2.13.5 Conduct a review of the contract, its financial and performance terms and its continuation.

2.13.6 Insure the appropriate use and control of respiratory medications.

2.13.7 Develop a plan for the regular replacement and upgrading of equipment.

Responsibility

- Lead Administrator
- COO

Contracted Services > Dietary Services

Assessment

- The service is outsourced to Morrison, a County contractor. It is accountable administratively to the Lead Administrator for Support Services.
- The contract expires in mid-2006 and only generally describes performance expectations in terms of satisfaction, regulatory compliance and management cooperation.
- There were no significant regulatory deficiencies identified in the last series of surveys.
- Total staff is 75 FTEs including 6 clinical dieticians.
- Quality of food in cafeteria is regarded as good. Limited information from patient surveys and anecdotal information supports assessment of good quality on inpatient units.
- Clinical staff interaction with nursing is good. Clinicians are reasonably well-integrated into the care planning process. Number of special diets is high.
- Management has been responsive to customer complaints with changes in menu, special services, catering.
- The kitchen area needs renovation and repair. Broken tiles, leaking faucets and peeling paint are chronic problems.

Contracted Services > Dietary Services

Deficiencies

- The physical facilities in the kitchen area are sub standard.
- Inconsistent implementation of dietary standards, I.e. accurate measurement of intake and output, variable portion size.
- Inconsistent assessment of patient specific dietary needs.

Recommendations

2.13.8 Review of the kitchen's facility needs should be undertaken. Specific timetables, costs and accountabilities should be developed.

2.13.9 Conduct a review of the cafeteria's aesthetics and traffic flow.

2.13.10 Ensure inservice classes are provided on therapeutic diets, proper food storage procedures and sanitation of equipment.

2.13.11 Institute a daily log to ensure that appropriate temperatures are being maintained and communicate the results go to the Ancillary IOP and then on to the Hospital IOP.

2.13.12 Include content on fluid restriction and portion size in the dietary orientation. Ensure Registered Dieticians monitoring fluid restrictions.

2.13.13 Conduct random reviews of cardexes and compare them to Affinity for issues and identify plans for resolution.

Contracted Services > Dietary Services

2.13.14 Establish a prioritized matrix to provide nursing information on the routine consults by dietary based on diagnosis.

2.13.15 Ensure all patients are receiving a nutritional assessment by a Registered Dietician.

Responsibility

- COO
- Dietary Director

Contracted Services > Security

Assessment

- Security is provided by The Office of Public Safety (OPS) of LA County, which is responsible for security services at all County facilities, not just hospitals.
- Management is perceived as knowledgeable and responsive.
- Security in the hospital's locale is a primary concern. Officers are perceived to be well trained and effective in prevention and detection. Rounds are staggered randomly to avoid a detectable pattern.
- The use of tasers as a means of dealing with menacing patients, particularly in Psychiatry, has been problematic. While there has been a decrease in injuries to both patients and staff as a result of their use, regulatory standards have required minimizing their use and only as a very last resort.
- Coordination with the campus Safety Officer and patient safety program is good.
- Leadership is in transition with the upcoming retirement of the current Director.

Contracted Services > Security

Deficiencies

- The use of tasers has been a significant regulatory barrier, and is perceived to be inconsistent with the hospital's overall duty to provide safe care.
- Officers who rotate onto the campus from other non-hospital County assignments do not have a standard orientation to KDMC.
- Leadership in the department is in transition, with the impending retirement of the department's Captain.

Recommendations

2.13.16 Review and update policies regarding the use of taser, reexamine them for their effectiveness and regulatory compliance.

2.13.17 Provide intensive inservicing regarding these new policies.

2.13.18 Insure compliance with these new policies.

2.13.19 Include these new policies in the standard orientation to KDMC and incorporated into the inservice required of each officer rotated onto the campus.

2.13.20 Execute mock codes on all three shifts across all services and identify gaps in response and resolve.

2.1.3.21 Develop a succession plan for leadership.

Contracted Services > Security

Responsibility

- Department Director (Captain) with OPS Chief
- COO

Contracted Services

Performance Measures

Respiratory Care

- Percentage of contractors have completed orientation
  - Current <50%
  - Target 100%
- Number of Required Services (identified in the contract) with Variance from the performance standard
  - Current 12
  - Target 0

Contracted Services

Performance Measures

Dietary Services

- Productivity: Worked hours per equivalent meal
  - Current not currently collected
  - Target 0.17
- Overall Satisfaction
  - Current not currently collected
  - Target TBD
- Time from Order to Tray Delivery
  - Current not currently collected
  - Target TBD
- Documentation of accurate Intake and Output
  - Current pending
  - Target 100%
- Percentage of patients who receive a nutritional assessment
  - Current pending
  - Target 100%

Contracted Services

Performance Measures

Security

- See Environment of Care Performance Measures
- Productivity: worked hours per 100 square feet patrolled
  - Current not currently collected
  - Target 0.20